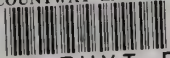
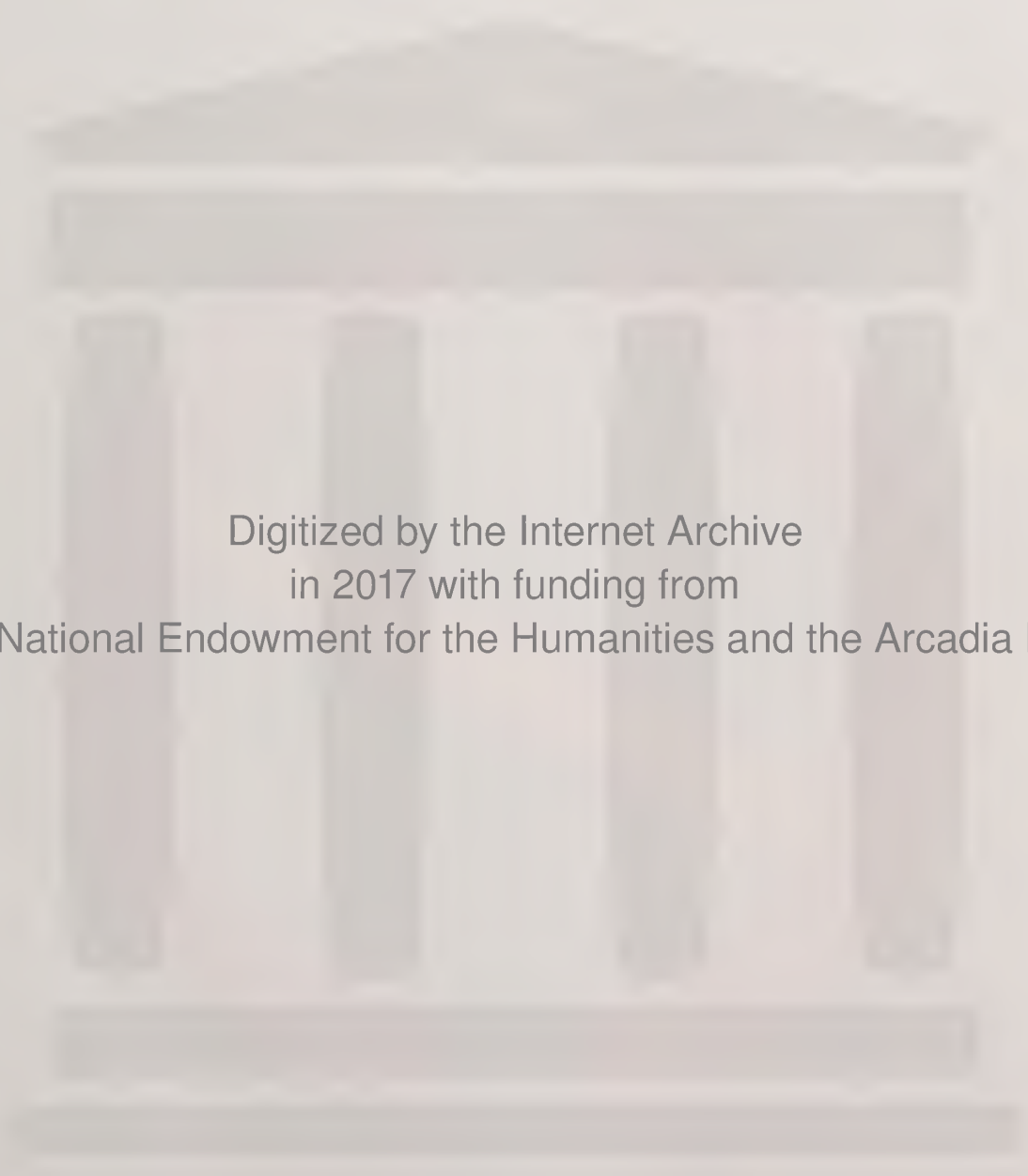


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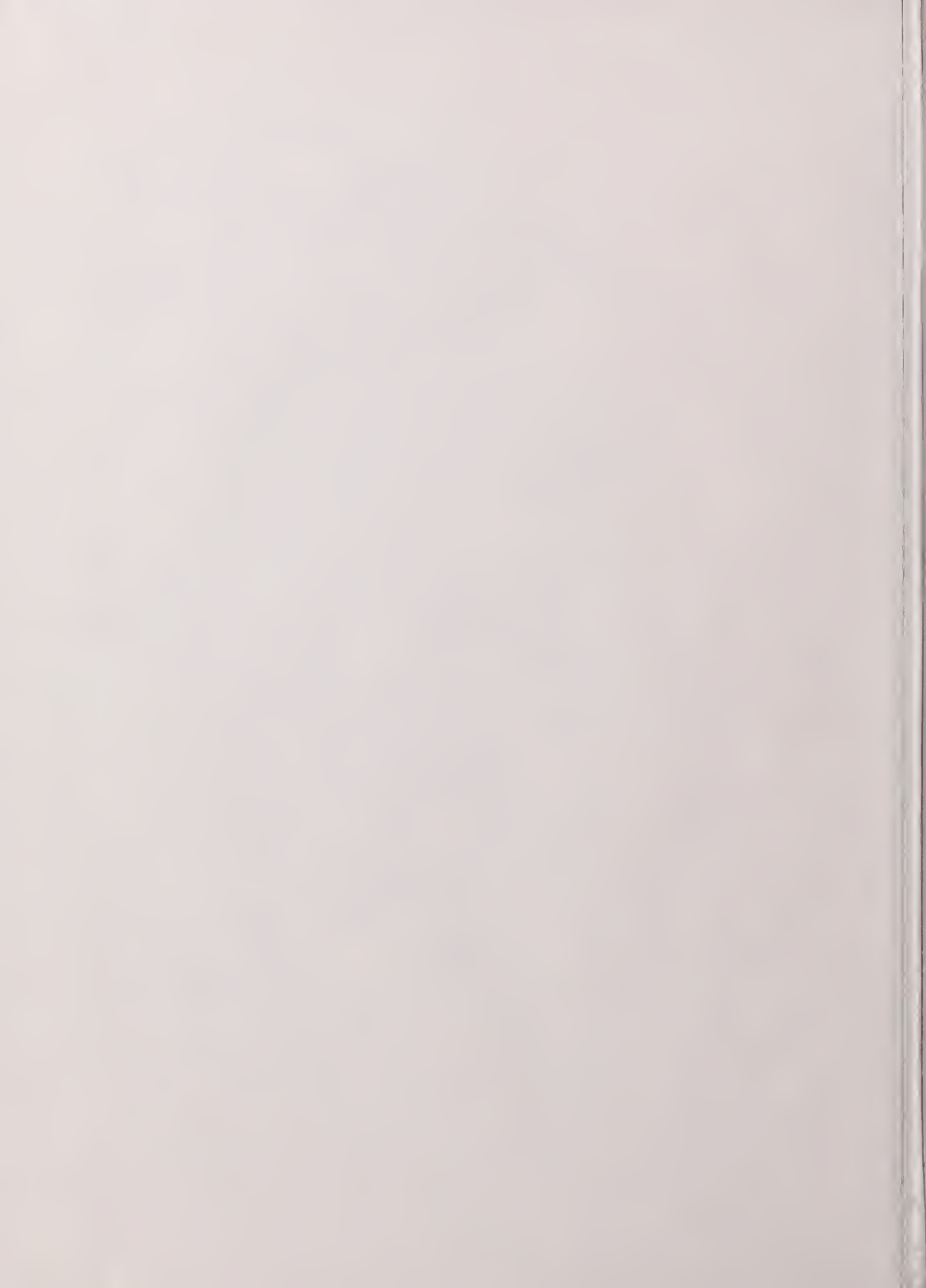


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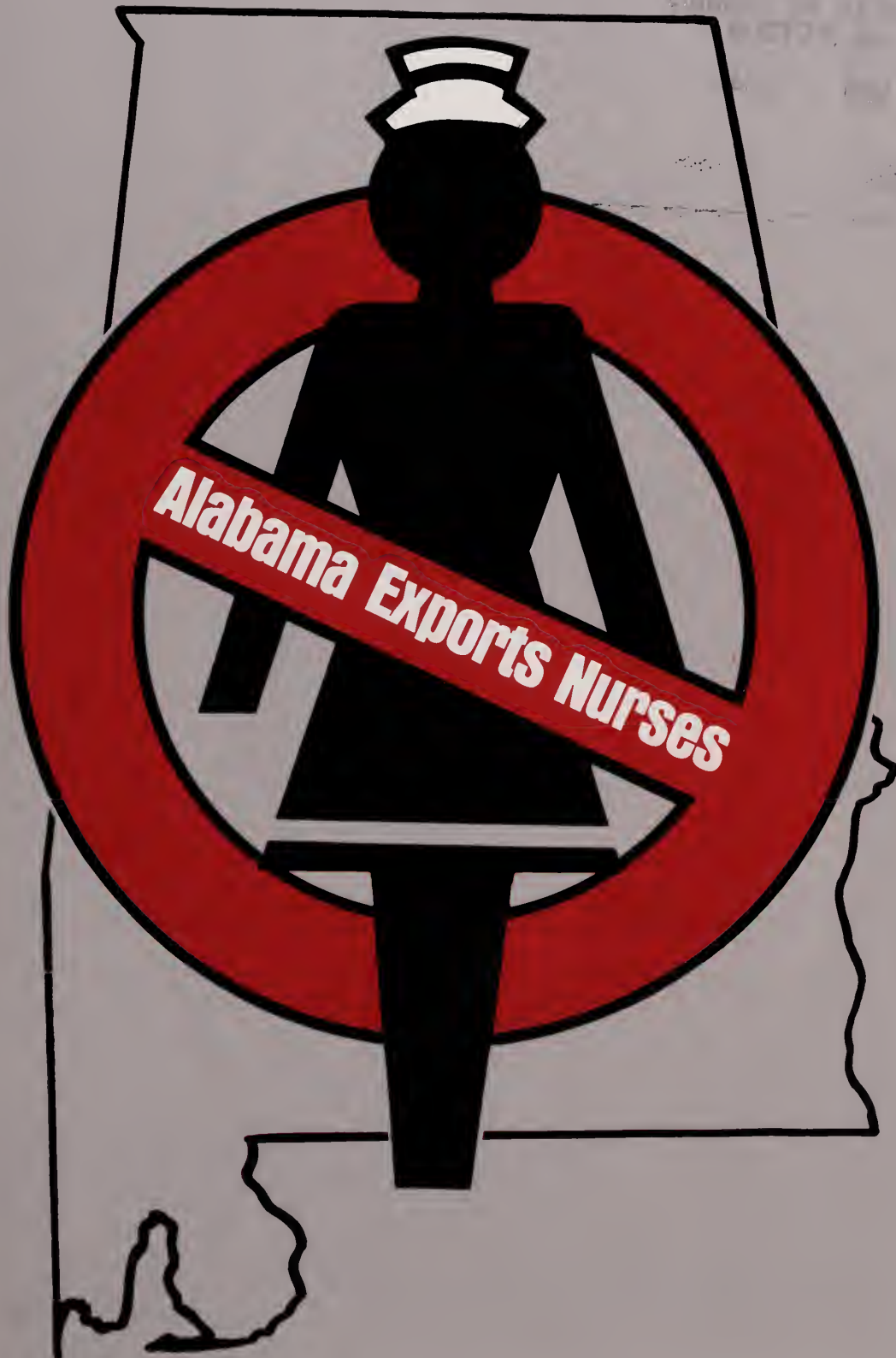


Alabama Medicine

JULY 1989

VOL. 29, NO. 7

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA



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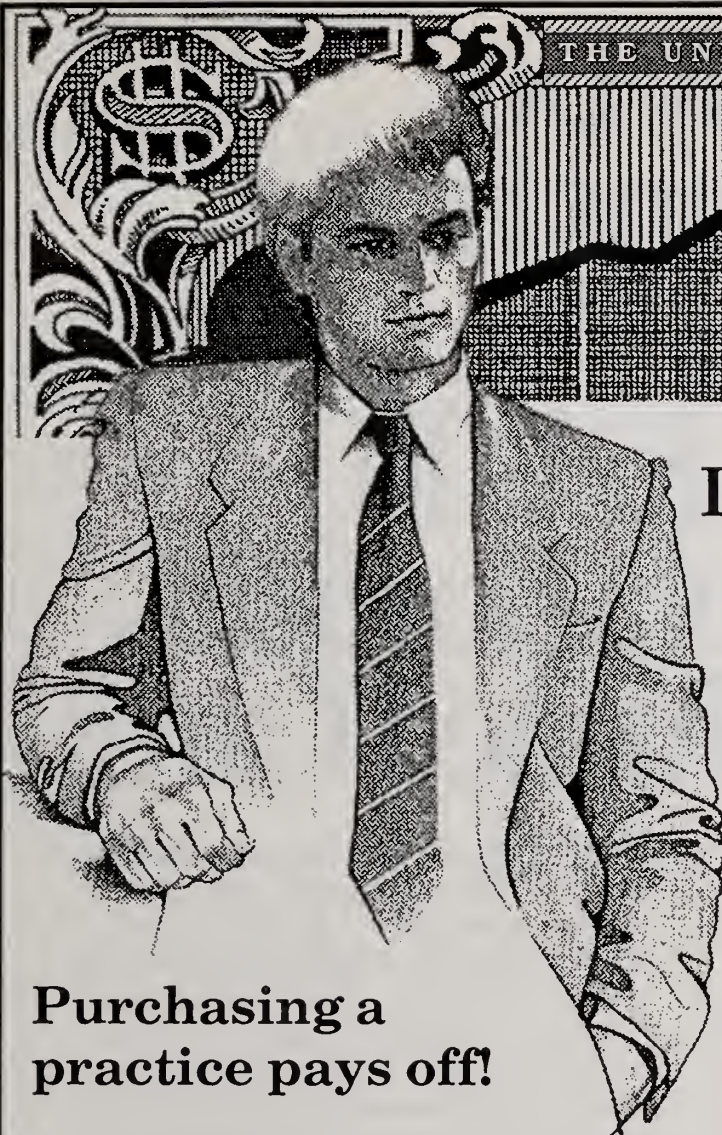
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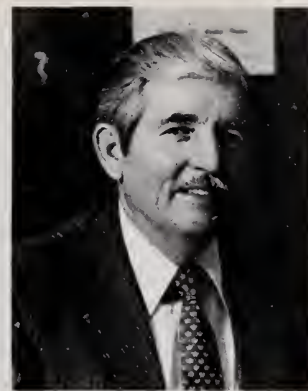
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S. Lon Conner
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Does This Shoe Fit You, Doctor?

During the years I have been your Executive Director, I have witnessed your elected Board and Officers discuss, time and again, the problem of apathy among member physicians.

In that time, I suppose several million words have filled the air over the central question facing all of organized medicine: how do you achieve and hold the constant involvement of the physician in all of the affairs of the Association?

By way of illustrating the universal nature of this, the No. 1 perplexing problem for medical leaders, let me turn the column over to one of them in a recent review of his 10-year attempt to get the attention of his colleagues:

"As I look through more than a decade of my . . . editorials, I am struck by the fact that while the practice of medicine has changed quite a lot, especially in the hospital, doctors have really stayed the same — and so have I.

"We're still making the same mistakes.

"We still don't read our mail. We still don't attend meetings on socioeconomic subjects. We still don't pay attention to proposed legislation which might have a profound effect on our practices.

"We don't participate in community affairs, because 'we don't have time.'

"We still think that just being a good doctor is enough. And some of us believe that, where the patient's health is concerned, we are the ones to decide on the appropriate treatment recommendations — not the government, not the insurance company. . . .

"That last belief is the biggest mistake of all. It hasn't been true for years.

"Have you tried to admit a patient on the evening before an operation lately? Have you tried to keep him in the hospital beyond the authorized length of stay?

Have you proposed a treatment that runs counter to the interpretation . . . of the latest *New England Journal of Medicine* pronouncement?

"If you have, then you know what I'm talking about. We are no longer in control because we haven't changed; we remain apathetic.

"Reminiscing over those old editorials brings back memories of recurring challenges and the realization that most . . . were written with one goal in mind: overcoming physician apathy.

"And if you think about it, our apathy has had a lot to do with where we are today, engaged in a major struggle to retain control of our practices.

"True, to be apathetic is to be human, as any cleric who has tried to stimulate his dozing blob of a congregation on an early Sunday morning can attest. But doctors, according to malpractice attorneys and juries, aren't supposed to be quite as human as everyone else, so perhaps we must be a little less apathetic than others.

"We need to become a lot less apathetic if we're going to have anything to say about how we want to practice in the future. Perhaps some of what has happened to us is for the greater good, but if so, it wasn't because of any effort on our part.

"How do we jolt ourselves and our colleagues out of our apathy? I don't know. If I did, my editorials would have been more successful.

"Carl Gustav Jung wrote: 'There can be no transforming of darkness into light and of apathy into movement without emotion.' Do we lack emotion? Undoubtedly. Can emotion be stimulated? Not until we are hit in our pocketbooks, unfortunately. And by then, it's too late — the law has been passed and the foothold lost.

"Robert Hutchins was writing about democracy, but what he wrote applies to other freedoms as well: 'The

death of democracy is not likely to be an assassination from ambush. It will be slow extinction from apathy, indifference and undernourishment.'

"If that is true, we are indeed an endangered species. Let us hope that those who write in these pages in the future can help arrest the process of extinction."

While I might not go as far as the author of these words in a few particulars, most of what he said pretty well describes the frustration I have seen over the same period of years. I have witnessed your officers beating their heads against the wall in their anguish over the lack of interest and involvement out there.


But it wasn't one of your officers writing these words. It was Wayne J. Boulanger, M.D., retiring Editorial Director of the *Wisconsin Medical Journal* in his final editorial in the June 1989 issue.

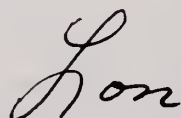
Reading his words, I had an uncanny feeling of *deja vu*. So, I suspect, will most of the Board members and Officers who have tried to represent your wishes faithfully over the years.

I say "tried" to represent you but because much of the time too many of you won't take the time to voice an informed opinion.

You do, of course, when some event shocks you out of your apathy, but even then your emotion cannot often be harnessed as useful energy because of your failure to keep abreast of developments all along. Your abdication of ongoing involvement may have rendered your opinion and your participation in addressing the event less than useful to your officers and Board of Censors members.

No unwelcome event that I can recall in the past decade occurred in a vacuum. It evolved into a crisis over time. But that evolution was not witnessed at all by all too many American physicians. They were too busy to bother, as Dr. Boulanger noted rather sadly, in the same mood of despair I have seen at meetings of MASA's Board, on the Councils of this Association, and on up through the deliberations of the American Medical Association — doctors gnashing their teeth because too many of their colleagues can't be bothered and are only moved to anger when the crisis finally materialized.

I think I speak for a succession of MASA and AMA leaders when I invite you to try on the Boulanger shoe. If it fits, wear it. 



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Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E. B. White, which emphasizes brevity, vigor and clarity.

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*Burt Taylor, M.D.
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The Nursing Crisis in Alabama, A “Supplier” State

After completing medical school, each physician spends a portion of every day working with and depending upon the men and women of the nursing profession. Many of us take nursing for granted. We speak with them via telephone night and day — weekends and holidays.

We are all part of the same medical team and we can only assume that nurses will always be available to work with us. But what would happen if the intensive care units, operating rooms, emergency departments, and medical-surgical nursing stations ceased to function because of a lack of trained and certified personnel? That scenario really doesn't seem possible. However, in some states it may become a reality.

In a few of our major cities the nursing care shortage has already reached the critical stage. Nurses are being bused from Maine to Boston, Massachusetts, to work weekend shifts and are receiving a full week's pay while only working two days. That certainly is helping Boston, but it is creating a tremendous problem for the physicians and hospitals in Maine. Similar situations have developed in many states.

There are statistics and there are statistics. . . . This shortage has occurred while reportedly there are more nurses in the workplace than at any other time in our history. There are approximately 1.9 million registered nurses (RN) and 0.8 million licensed practical nurses (LPN), for a total of 2.7 million nurses.

Sixty-eight percent of the RNs are employed in hospitals. Seventy-one percent of the hospital's nurse force are technical nurses with a two-year associate degree

or a three-year diploma preparation. Approximately 7% of all RNs are working in nursing homes and long-term care facilities.

Reviewing the history of nursing in the U.S. reveals that since 1954 the Hospital Base Diploma Programs have continued to decline. In 1965, The American Nurses Association published a position paper supporting two levels of entry into practice. The Associate Nursing Degree (ADN) from community colleges and the four-year Bachelor of Science Nurse, the BSN.

In 1979, the shortage of nurses was recognized by organized medicine; however, during the recession of the early 1980s nursing shortages were not reported. In 1986, physicians complained that a shortage of nurses had resulted in the closing of many critical care units and medical-surgical beds. Studies revealed that the shortage of nurses was affecting “select” populations, particularly the Atlantic States, California and parts of the South.

Why do we have this shortage? Organized nursing has suggested several reasons. They feel that there is a lack of economic incentive to remain at the bedside. There has been an increased demand for nurses in hospitals due to increased acuity of care. Additionally, organized nursing is concerned about the bureaucratic and autocratic physician-nurse relationship.

Educational policies have accentuated leadership skills and primary care rather than the technical skills now required in critical care and operating room nursing. There is a decreased applicant pool for health care professions. At the same time, there has been a tre-

mendous increase in the female percentage of medical school entrants and graduates. The same thing is occurring in law schools.

As a result of the above, the American Medical Association has requested that pilot programs be initiated in certain areas of the United States to study the feasibility of registered care technologists (RCTs). The AMA reminds us that there are several kinds of technicians who already deliver direct patient care in our hospitals. These include technicians specializing in surgery, respiratory therapy, emergency medicine dialysis and many other areas.

The RCT program would be offered to high school graduates and provide instruction for three contiguous levels of training. An *assistant* RCT would require two months of training. The primary function at this level would be that of a bedside aide.

The *basic* RCT would be completed after an additional seven months of training. At that point, the RCT would be eligible for licensure. The basic RCT would subsidize work now performed at the level of licensed practical nurses.

To attain *advanced* RCT would require an additional nine months of "highly technical education."

Needless to say, this proposal has been controversial and has not been supported by the nursing community. The delegates to the AMA from our State did *not* endorse the RCT program.

With the above information as a background, I would like to review briefly the nursing situation in Alabama as outlined by the Alabama Board of Nursing in their 1987-88 annual report.

As of Sept. 30, 1988, there were 35 approved registered nursing programs and 22 practical nursing programs in the State of Alabama. During the fiscal year 1987-88, there were 1,618 candidates for the state RN examination and 973 candidates for the state LPN examination.

During that same year, there were 860 RNs and 304 LPNs who were granted an Alabama license by endorsement from other states. In 1988, the Board recorded 30,053 currently licensed RNs and 15,932 currently licensed LPNs.

A disturbing statistic reveals that Alabama is a "supplier" state in that it endorses more nurses to other states than are endorsed into the State of Alabama each year. During the above fiscal year, 1,664 RNs and 449 LPNs were endorsed to other State Boards of Nursing.

A review of the 30,000 nurses licensed in Alabama in 1988 revealed that 2,146 were not employed and

3,749 were located out of the State of Alabama. Of the total registered nurses, 95% were female; 60% were under 40 years of age; 60% had been licensed for less than 10 years.

In 1978, Alabama issued licenses to 2,246 RNs and 1,379 LPNs. In 1988, Alabama licensed 2,106 RNs, and 965 LPNs.

In 1978, 647 nurses were endorsed from Alabama to another state. In 1988, 1,664 were endorsed from Alabama to another state.

In 1978, there were 33 registered nursing programs; 3,358 applicants were admitted, while 1,646 withdrew, resulting in 1,572 graduates. In 1988, there were 35 programs with 2,364 admissions that year; 906 withdrew, and 1,473 graduated. The total enrollment in all of the RN programs in 1978 was 5,103, while in 1988 it was 2,934.

As I mentioned above, there are statistics and there are statistics. All of us realize that nursing is a primary cog in the medical machine. It is mandatory that the physicians of Alabama work with their hospitals and try to improve the working conditions for our nurses.

With the tremendous cost constraints facing the hospitals in Alabama, the chance for significant monetary improvement will be limited and in most cases will not be under the direct control of the physicians. However, the physicians should be able to improve the working environment for the nurses across this state. The County Medical Societies and the State Medical Association should begin to assist in some tangible ways.

Some questions for your consideration:

- 1) Would you recommend a nursing career for your family or friends? If not, why not?
- 2) Are you satisfied with the nursing situation in your community and hospital?
- 3) What could individual Alabama physicians do to improve the attractiveness of a career in nursing?
- 4) What should our State Medical Association be doing to ensure a strong nursing profession in Alabama?
- 5) Do you agree with our position regarding the RCT program?

The nursing profession has a strong and proud history. Its members are deeply concerned about the welfare of our patients. Hopefully, we can eventually have the State of Alabama dropped from the list of "supplier" states.

I would welcome your comments and suggestions.



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Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the incidence of enteropancreatic (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,800 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice. In a two-year study in mice, there was no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 550 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established. Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT/SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported. **Endocrine** — Clinical pharmacology studies and controlled clinical trials showed no evidence of antihypertensive activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H₂-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H₂-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg, respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Viridans Streptococcal Endocarditis

LeRoy F. Harris, M.D.*

Abstract

Although responsible for a declining proportion of cases of infective endocarditis, viridans streptococci remain the commonest cause and accounted for 30% of our cases seen in Huntsville, Alabama. Usually viridans streptococcal endocarditis is associated with dental manipulation or infection and underlying heart disease but both conditions were not common in our series. Similar to the experience of other investigators, our patients exhibited a subacute course with fever, dyspnea, weight loss and heart murmur. Echocardiography, reported useful in detecting vegetations in one series, was not a sensitive diagnostic tool in our patients. We confirmed the low relapse rate and mortality rate associated with earlier reports of viridans streptococcal endocarditis but observed a high rate of complications, as noted in a recent series.

Although responsible for a declining proportion of cases of infective endocarditis, viridans streptococci remain the most common cause. Earlier series demonstrated the relatively favorable clinical outcome of viridans streptococcal endocarditis while a more recent report concluded that endocarditis due to viridans streptococci could be associated with a virulent clinical course.¹ We review our experience with viridans streptococcal endocarditis with emphasis on the epidemiology, clinical presentation, laboratory, radiographic and echocardiographic findings, treatment and prognosis and compare our cases with previous series.

Patients and Methods

We reviewed the charts of all patients with a final discharge diagnosis of infectious endocarditis admitted to the three community hospitals of Huntsville, Alabama, during the ten-year period of 1978 through 1987,

inclusive. Endocarditis was defined as a compatible clinical illness if two or more blood cultures contained the same organism. Although not required for inclusion in this series, surgical or autopsy confirmation of the diagnosis was sought whenever possible. Endocarditis was considered to be caused by viridans streptococci when blood cultures contained only those organisms. Charts of all patients with viridans streptococcal endocarditis were examined in greater detail. Viridans streptococci were identified on Gram stain as gram-positive cocci. They demonstrated alpha hemolysis on blood agar plate, yielded a negative catalase reaction, did not grow in bile-esculin medium and trypticase soy broth with 6.5% sodium chloride and were not inhibited by ethyl hydrocuprein hydrochloride. Serum cidal levels were performed by the modified Schlichter serum antibacterial potency test.

Results

Table 1 lists the number and percentage due to individual organisms of 56 cases of infectious endocarditis. Viridans streptococci accounted for 17 cases (30%) followed by coagulase-negative staphylococci 12 cases (21%), *Staphylococcus aureus* 11 cases (20%), enterococci 7 cases (13%), nonenterococcal group D

TABLE 1
Infectious Endocarditis — Huntsville, Alabama,
1978-1988

Organism	Number of cases	(%)
Viridans streptococci	17	(30)
Coagulase-negative staphylococci	12	(21)
<i>Staphylococcus aureus</i>	11	(20)
Enterococci	7	(13)
Nonenterococcal group D streptococci	4	(7)
Group B streptococci	2	(4)
Other	3	(5)
Total	56	(100)

Note: Other = group G streptococci 1 (2),
Cardiobacterium hominis 1 (2), *Neisseria subflava* 1 (2)

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TABLE 2
Viridans Streptococcal Endocarditis — Clinical Features

<i>Case No.</i>	<i>Age/ Sex</i>	<i>Predisposing factors</i>	<i>Valve involved</i>	<i>Symptoms</i>	<i>Signs</i>	<i>T max (°F)</i>
1	58/M	None	Aortic	Fever, low back pain-1 mo	Sys M	100
2	59/M	Mitral valve prolapse, dental manipulation	Mitral	Fever-3 mo	Sys M	100.6
3	54/M	Rheumatic heart disease	Mitral	Fever-3 wk	Sys M	100.2
4	26/M	None	Mitral	Fever, abdominal pain-2 d	Sys M	98.8
5	65/F	Rheumatic heart disease	Mitral	Dyspnea, weakness-6 mo	Sys M	98.6
6	52/M	None	Mitral	Fever, joint pain-2 mo	Sys M	101.6
7	73/M	None	Mitral	Fever, weight loss-4 mo	Sys M	99.3
8	43/F	Calcific, bicuspid aortic valve	Aortic	Dyspnea-2 mo	Sys M	99
9	45/M	Mitral valve prolapse	Mitral	Fever, weakness-3 wk	Sys M	100
10	66/F	Mitral insufficiency	Mitral	Fever, R hemiparesis-1 d	Sys M	101
11	20/M	Mitral valve prolapse	Mitral	Fever-2 wk, L hemiparesis, aphasia-1 d	Sys M	101.8
12	53/M	None	Mitral	Fever-2 mo	Sys M	102.4
13	62/M	None	Mitral	Fever-1 mo	Sys M	101.6
14	26/M	IV drug abuse	Aortic and mitral	Dyspnea, weight loss-4 mo	Sys and dias M	100.9
15	73/F	Alcoholism	Aortic	Altered mental status-4 mo	Sys M	100.6
16	75/M	Aortic sclerosis	Aortic	Fever, dyspnea-1 mo	Sys M	99.8
17	31/M	Poor oral hygiene	Aortic	Fever, weakness, weight loss-1 mo	Sys and dias M	101.4

Note: T max = maximum temperature during first 24 h of hospitalization, sys = systolic, M = murmur, dias = diastolic.

TABLE 3
Viridans Streptococcal Endocarditis — Laboratory, Radiographic and Echocardiographic Findings

<i>Case No.</i>	<i>WBC (cells/cu mm)</i>	<i>Peak serum cidal level</i>	<i>Chest x-ray</i>	<i>Echocardiogram</i>
1	9,300	1:2	L costophrenic scarring	No vegetation
2	10,300	—	Normal	Vegetation, mitral valve prolapse
3	7,130	—	Normal	Vegetation
4	27,450	—	Normal	Thickened mitral valve
5	16,900	—	Pulmonary edema	Vegetation
6	7,890	—	Normal	—
7	8,140	—	Normal	Calcified mitral valve
8	8,200	—	Normal	—
9	8,700	—	Normal	Mitral valve prolapse
10	10,100	—	Congestive heart failure	No vegetation
11	12,100	≥1:1024	Normal	Mitral valve prolapse
12	6,000	—	R lung infiltrate	No vegetation
13	7,400	1:64 (penicillin, streptomycin)	Normal	No vegetation
		1:16 (vancomycin)		
14	8,400	1:16	Cardiomegaly, pleural effusion	Vegetation
15	5,600	≥1:1024	Cardiomegaly	Thickened aortic valve
16	9,110	—	Normal	Thickened aortic valve
17	7,380	1:32	Normal	Thickened aortic valve

Note: WBC = leukocyte count on admission to hospital, peak serum cidal level = serum bactericidal level drawn within two hours of administration of one or both antibiotics

TABLE 4
Viridans Streptococcal Endocarditis — Treatment, Outcome and Complications

Case No.	Treatment		Outcome	Complications
	Medical	Surgical		
1	Cefazolin - 4 wk	—	Cure	L ₅ S ₁ disc space infection
2	Pen - 4 wk	MVR	Relapse	Subclavian catheter infection
3	Pen and strep - 2 wk	—	Cure	—
4	Pen and strep - 2 wk	—	Cure	—
5	Pen - 3 d	MVR	Death	CHF
6	Pen and strep - 2 wk	—	Cure	—
7	Pen - 4 wk	—	Cure	—
8	Cefazolin - 3 d	AVR	Death	CHF
9	Pen - 4 wk and strep - 2 wk	—	Cure	—
10	Pen - 4 wk	MVR 2 mo later	Cure	CHF, cerebral embolus
11	Pen - 4 wk and strep - 2 wk	—	Cure	Cerebral embolus
12	Pen - 4 wk and strep - 2 wk	—	Cure	Mycotic aneurysm
13	Pen and strep - 2 wk then vancomycin - 2 wk	—	Cure	Retinal artery embolus
14	Pen - 4 wk	MVR and AVR	Cure	CHF
15	Pen - 4 wk	—	Cure	—
16	Pen - 4 wk	—	Cure	—
17	Vancomycin - 4 wk	—	Cure	—

Note: Pen = penicillin, MVR = mitral valve replacement, strep = streptomycin, CHF = congestive heart failure, AVR = aortic valve replacement

streptococci 4 cases (7%), group B streptococci 2 cases (4%) and other bacteria 3 cases (5%).

Table 2 describes the clinical features of 17 patients with viridans streptococcal endocarditis. The patients ranged in age from 20 to 75 years and averaged 52 years. Over three-quarters of the patients were males. Factors predisposing to the development of endocarditis included an abnormal heart valve in eight patients and dental manipulation, IV drug abuse, alcoholism and poor oral hygiene in one patient each, respectively. For six patients no predisposing conditions were elicited. The mitral valve was infected twice as often as the aortic valve and all but one patient had single valve involvement. Fever was the most frequent symptom succeeded by dyspnea, weakness and weight loss. The duration of symptoms extended from one day to six months with a mean of two months. In all patients a systolic murmur was appreciated and a diastolic murmur was auscultated in two cases. The maximum temperature during the first 24 hours of hospitalization ranged from 98.6 to 102.4° and averaged 100.4°F.

Table 3 enumerates the laboratory, radiographic and echocardiographic findings of 17 cases of viridans streptococcal endocarditis. The leukocyte count on admission to the hospital extended from 5,600 to 27,450 per cu mm with a mean of 10,000 per cu mm. Peak serum cidal levels were obtained in seven patients and all but one titer exceeded 1:8 (the minimal level usually advocated as effective treatment for endocarditis). The chest x-ray was interpreted as normal in 11 patients

and abnormal in six patients. The most common abnormality was related to some degree of congestive heart failure. The echocardiogram detected vegetations in four patients and abnormal heart valves (prolapse, thickening) in eight patients.

Table 4 discloses the treatment, outcome and complications of 17 cases of viridans streptococcal endocarditis. Treatment consisted of penicillin in 13 patients which was combined with streptomycin in seven patients. Two patients received cefazolin and vancomycin was administered to one patient. In addition one patient was given penicillin followed by vancomycin. All patients except two received at least two weeks of therapy. Valve replacement was required during the active phase of endocarditis in four patients and two months after completion of antibiotic administration in one patient. Two of the patients died for a 12% mortality rate and one patient relapsed. Complications of endocarditis or its treatment were encountered in slightly over half of the cases and included congestive heart failure (four patients), embolization (four patients) and disc space infection and subclavian catheter infection (one patient each, respectively).

Discussion

Viridans streptococci are a heterogeneous group of organisms which are identified by various cultural, biochemical and serologic attributes. Viridans streptococci have been speciated by Colman and Williams

TABLE 5
Species of Viridans Streptococci

<i>Colman and Williams</i>	<i>Facklam</i>
<i>S. mitor</i>	<i>S. Mitis</i>
<i>S. sanguis</i>	<i>S. sanguis II</i>
<i>S. milleri</i>	<i>S. sanguis I</i>
	<i>S. MG-intermedius</i>
	<i>S. anginosus-constellatus</i>
<i>S. salivarius</i>	<i>S. salivarius</i>
<i>S. mutans</i>	<i>S. mutans</i>
	<i>S. morbillorum</i>
	<i>S. acidominimus</i>
	<i>S. uberis</i>

and by Facklam but unfortunately the nomenclature of the two schemes is not identical which has resulted in confusion. Table 5 depicts the corresponding classification of both schemes. The primary habitat of viridans streptococci comprises the oral cavity and the bacteria also have been isolated from skin and stool.²

In the preantibiotic era viridans streptococci were responsible for up to 90% of cases of infective endocarditis but this percentage has declined to 30 to 50% in more recent series. From 15 to 50% of cases of viridans streptococcal endocarditis are presumed secondary to transient bacteremias originating from dental manipulation or infection. Production of dextran by viridans streptococci and the lipoteichoic acid component of their cell wall are two substances which are postulated to promote adherence of the organisms to damaged heart valves during these transient bacteremias. Most patients with viridans streptococcal endocarditis possess underlying heart disease; commonly rheumatic heart disease in the preantibiotic era and rheumatic heart disease, congenital heart disease and mitral valve prolapse in the postantibiotic era. The vast majority of cases involve the left side of the heart with the mitral valve infected almost twice as frequently as the aortic valve.^{1, 3} In our series viridans streptococci caused 30% of cases of infectious endocarditis. In only two patients was a possible dental origin of infection present and no underlying heart disease was identified in almost 50%. Similar to the findings of other investigators, we encountered left sided cardiac infection with a two to one mitral valve predominance.

Viridans streptococci classically cause a subacute endocarditis. The onset is insidious with weeks to months elapsing before diagnosis. The common clinical manifestations include fever, malaise, arthralgia, headache, dyspnea, weight loss, heart murmur, splenomegaly and skin rash.^{1, 2} One report described vegetations detected by echocardiography in 72% of patients.¹ Our patients presented commonly with fever, dyspnea, weakness and weight loss with an average

duration of two months. A heart murmur was appreciated on physical examination in all patients. Echocardiography, however, revealed vegetations in slightly less than one-quarter of patients.

The treatment of penicillin-sensitive viridans streptococcal endocarditis (defined as a minimal inhibitory concentration 0.2 µg/ml) can be accomplished with any of the three following regimens: aqueous crystalline penicillin G, 10-20 million units per day, for four weeks; aqueous crystalline penicillin G, 10-20 million units per day, for four weeks combined with streptomycin, 7.5 mg/kg body weight (not to exceed 500 mg) every 12 hours, for the first two weeks; or procaine penicillin G, 1.2 million units every 6 hours, in combination with streptomycin, in the dose mentioned earlier, both for two weeks. A cure rate of at least 98% has been recorded with each of these therapies. For patients older than 65 years, those with impaired renal function and those with preexisting vestibular disease, the four week penicillin treatment course is advised because of the risk of streptomycin-associated vestibular toxicity. The four week penicillin regimen combined with streptomycin for the first two weeks is suggested for patients with concomitant intracranial infection and for patients with prosthetic valve endocarditis due to viridans streptococcus. Therapeutic options for patients allergic to penicillin include vancomycin, 7.5 mg/kg body weight (not to exceed 500 mg)



**Harold Yuker is Provost
of Hofstra University.
He has cerebral palsy.**

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every 6 hours, or cephalothin, 2 g every 4 hours, for four weeks.⁴

Approximately 10% of viridans streptococci causing endocarditis are nutritionally variant; they require pyridoxine supplemented media for growth. Although their susceptibility to penicillin is similar to that of other viridans streptococci, the nutritionally variant strains causing endocarditis demonstrate a higher relapse rate. Therefore, it is recommended that patients with nutritionally variant viridans streptococcal endocarditis receive four weeks of penicillin together with an aminoglycoside.⁵

In recent years it has been appreciated that not all viridans streptococci are highly susceptible to penicillin.⁶ Patients with endocarditis due to these relatively penicillin-resistant strains (defined as a minimal inhibitory concentration $\geq 0.2 \mu\text{g/ml}$) also exhibit a higher rate of relapse and should be treated with a regimen appropriate for enterococcal endocarditis: penicillin combined with an aminoglycoside for four to six weeks.⁴

In our series patients received a variety of treatment regimens including penicillin with or without streptomycin, cefazolin and vancomycin. Only one patient relapsed and the two patients who died were treated

for only three days before their death (12% mortality rate). However, almost 50% of our patients developed complications directly attributable to their endocarditis consisting of congestive heart failure (four patients), cerebral embolus (two patients) and disc space infection, mycotic aneurysm and retinal artery embolus (one patient each). This virulent course for viridans streptococcal endocarditis is in agreement with the results of a recent series.¹

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Intraluminal Irradiation for Inoperable Obstructing Endobronchial Carcinoma of the Lung

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Abstract

Between April 1, 1987 and August 31, 1988, 31 patients with inoperable symptomatic obstructing carcinoma of the lung underwent 79 intraluminal irradiation sessions in an effort to re-establish patency of the airway. Palliation was excellent, 74% of the patients had complete relief of atelectasis, while two patients with extensive tracheal disease experienced little objective response. There was little morbidity, other than that associated with bronchoscopy. Overall, survival at 6 months was 55% with 22% of patients at risk for 18 months surviving. This compares favorably with the more complicated technique of laser resection for relieving malignant airway obstruction.

The management of technically or medically inoperable patients with malignant airway obstruction is a difficult therapeutic challenge. Although external beam irradiation may relieve pain or hemoptysis, only 23% of patients experience relief of atelectasis and improvement in hypoxia.³ Recent efforts to immediately re-establish the airway have included laser

resection, intraluminal irradiation, or a combination of the two. Intraluminal irradiation has included both low and high dose rate remote after loading devices which unfortunately, are prohibitively expensive for many community radiation oncology departments. We have perfected a simple, inexpensive, effective system of intraluminal irradiation which can be performed at most community hospitals.

Methods and Materials

Between April 1, 1987 and August 31, 1988, 31 patients underwent 79 intraluminal irradiation sessions for inoperable symptomatic obstructing carcinoma of the lung. All but one patient had non-small cell carcinoma of the lung. A single patient with markedly symptomatic small cell carcinoma of the lung who refused chemotherapy underwent emergency intraluminal irradiation to re-establish patency of the airway.

Initially, the procedure was limited to patients in which there were little therapeutic options remaining. These included 8 patients who had experienced no objective response to external beam irradiation or who had prior external beam irradiation with partial regression of disease followed by symptomatic recurrence.

An additional four patients underwent intraluminal irradiation alone as their only therapy. Three patients had severe chronic obstructive pulmonary disease and would not tolerate even limited field external beam irradiation. A single patient had undergone prior pneumonectomy for carcinoma and subsequently developed

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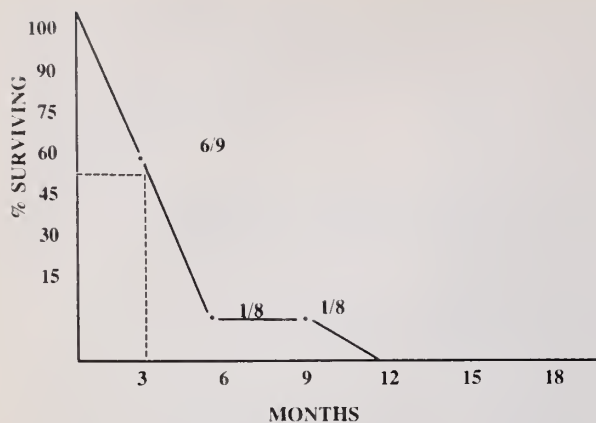


Figure 1: Actuarial survival — palliative irradiation.

a new primary in the remaining lung and was not a candidate for external beam irradiation or resection.

Nine patients with a poor performance status due to coexisting medical illness, advanced age, or prior ischemic stroke were not candidates for a protracted course of curative irradiation and were treated with palliative intent. These patients received a short course of external beam irradiation typically 3,000 to 4,000 cGY in combination with one or two intraluminal irradiation sessions.

As we became convinced of the efficacy and safety of this procedure, we extended it to include patients with a good performance status in whom an attempt at curative external beam irradiation was to be made. Typically, patients received intraluminal irradiation at the time of diagnosis to expedite relief of their symptoms. By clearing the postobstructive pneumonia and atelectasis, this allowed more accurate placement of the external beam irradiation fields minimizing the uninvolved lung exposed to high dose external irradiation. Patients typically received 4,000 cGY to the primary tumor and regional lymphatics to include the mediastinum. The visible tumor was then boosted to 6,120 cGY in 34 fractions.

Technique of Intraluminal Irradiation

Our current technique involves placement of a single after loading implant catheter via the flexible bronchoscope. The catheters employed have a closed end, are 2 millimeters in diameter, 100 centimeters in length with an internal metal guide wire. High intensity iridium 192 which is specially ordered and is maintained in the Department of Radiation Oncology is utilized as the radioactive source. The distal 8 centimeters of the wire is radioactive and delivers approximately 300 cGY per hour at 1 centimeter distance from the mid-portion of the radioactive end. As the implant catheter has a closed end, the radioactive iridium 192 wire can be used repeatedly. Once the wire has decayed to the point that it requires greater than three hours to deliver

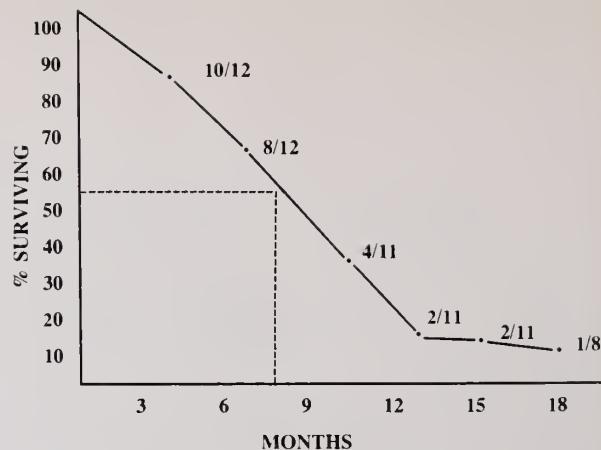


Figure 2: Actuarial survival: primary or salvage intraluminal irradiation.

600 cGY, typically two months, it is then replaced with a new more intense wire.

Provided the patient is medically stable, the intraluminal irradiation session can be performed as an outpatient. The patient is asked not to eat anything after midnight. They present to the Outpatient Department where a heplock is placed and are then transported to the bronchoscopy suite where a local anesthesia is administered. Following bronchoscopic evaluation of the obstructing tumor, the flexible implant catheter is introduced via the biopsy channel of the bronchoscope. The catheter is pushed beyond the area of obstruction and its position verified with the fluoroscopy unit. Following catheter placement, the bronchoscope is slowly withdrawn over the catheter continually observing its position by fluoroscopy. Once the bronchoscope is withdrawn, the catheter is then secured to the patient's nasal bridge with tape. The patient is then transported from the bronchoscopy suite to a private room for radiation isolation. There the metal guide wire is withdrawn and the radioactive iridium 192 wire is inserted by hand. Following administration of 600 cGY, the iridium wire and catheter are removed and the patient is discharged home. The entire

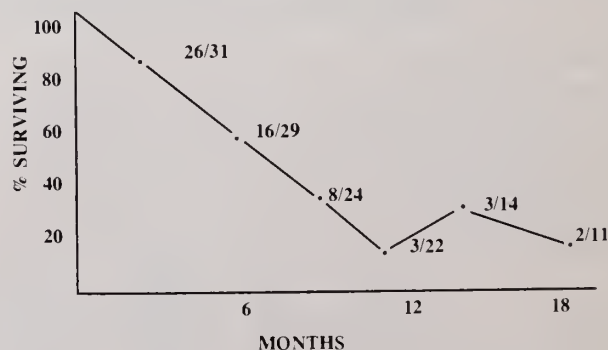


Figure 4. Actuarial survival: all patients.

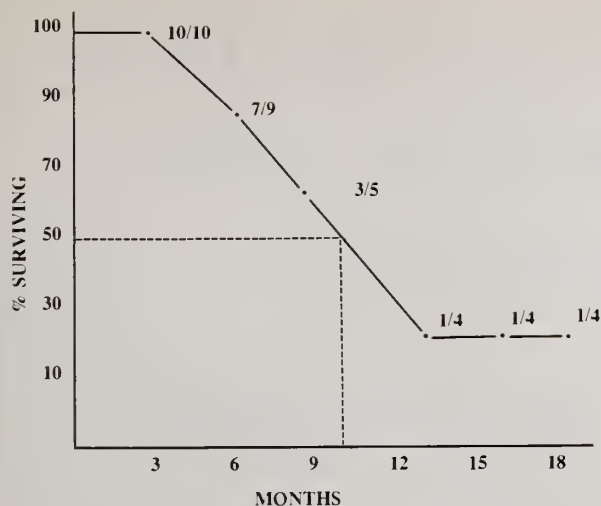


Figure 3: Actuarial survival: curative external and intraluminal irradiation.

procedure typically requires less than four hours minimizing the patient's discomfort and expense. The procedure is repeated in several days as necessary until relief of obstruction.

Results

Relief of Bronchial Obstruction: All patients experienced subjective improvement in their symptomatology. Twenty-three (74%) of the patients had complete relief of symptoms, while six (20%) had persistent, typically asymptomatic subsegmental atelectasis seen on chest x-ray. Several patients experienced intermittent persistent cough controlled with antitussives. Two of the initial patients, early in our experience, were referred for treatment of advanced tracheal carcinomas refractory to maximal doses of external beam irradiation. Although both patients had a transient subjective improvement in stridor and dyspnea, at follow-up bronchoscopy, there was little objective response with significant persistent tumor and both expired within three months.

Survival: Survival was calculated as the percentage of patients alive during the time interval from the date of their initial intraluminal irradiation session. This series includes a spectrum of patients which ranges from those with a poor performance status, at times bedridden, undergoing low dose palliative therapy to those receiving high dose curative irradiation. Figure 1 demonstrates the survival of 9 patients receiving palliative treatment. As can be seen, their median survival was poor, typically in the range of three months with no patient surviving beyond one year.

The survival of 12 patients undergoing intrabronchial irradiation as their only therapy or as salvage following previous external beam irradiation was similar and is shown by Figure 2. Eight of the twelve

patients were in the salvage category and represent a select group in that they had experienced locally recurrent disease after a period of observation without developing distant metastasis. Their survival in fact approaches that of patients undergoing curative external beam irradiation in conjunction with intrabronchial treatment.

The survival of 10 patients receiving curative external beam and intrabronchial irradiation is shown by Figure 3. As can be seen, the median survival was slightly in excess of nine months with 1 of 4 patients at risk alive at eighteen months.

The survival at six months for the entire group of 31 patients receiving intraluminal irradiation is 55% which compares favorably to other reported series.^{1, 2, 4} As can be seen in Figure 4, 2 of 11 patients at risk are alive at eighteen months.

Etiology of Death: 23 patients (74%) have died during the period of follow-up. The etiology of their demise, as best determined by the authors or their local physician, is shown in Table 1. As can be seen, the majority of deaths (43%) were the result of distant metastasis. Five patients (22%) died of intercurrent disease, typically of ischemic stroke or myocardial infarction. In most cases, we were unable to determine if their malignancy contributed to their demise. Four patients experienced recurrent airway obstruction due to extensive mediastinal disease resulting in extrinsic bronchial compression which would not benefit by further intrabronchial irradiation.

Four patients experienced a fatal exsanguination. Two of these at one and three months respectively. The patient that died one month following intrabronchial irradiation was hospitalized at the time of his demise and an autopsy revealed that tumor had eroded into the pulmonary artery. Two patients experienced delayed fatal exsanguination at nine and ten months respectively. One of the patients dying of delayed exsanguination had undergone bronchoscopy several weeks prior to his death and was found to have recurrent disease. However, due to his poor medical condition and the extreme distortion of the bronchial anatomy, it was not felt that further intrabronchial irradiation would be of value. Therefore, we presume

Table 1.		
Etiology death for patients undergoing intraluminal irradiation		
	No. Pts.	%
Distant metastasis	10	43
Medical illness	5	22
Recurrent airway obstruction	4	17
Fatal bleed	4	17
	23/31	(74%)

that he also died as a result of tumor extending into a major artery. It is unclear if the other two exsanguinations were exacerbated by the intrabronchial irradiation. However, at follow-up bronchoscopies we have not encountered mucosal or cartilaginous necrosis of the tracheal or bronchial tree.

Conclusions

We feel that intraluminal irradiation as administered by our technique is an effective modality to relieve symptomatic malignant airway obstruction. It is simple and can be performed as an outpatient procedure. There is minimal morbidity other than the discomfort of bronchoscopy. The 55% survival at six months for patients undergoing intraluminal irradiation appears comparable to the 40-50% seen by institutions utilizing laser resection to relieve symptomatic airway obstruction.^{1, 2, 4} Although patients benefit with an improved quality of life by relief of airway obstruction, it is unclear whether long term survival will be significantly improved.

Discussion

Thirty-one consecutive patients with inoperable symptomatic malignant airway obstruction underwent intraluminal irradiation over a seventeen month period.

The primary goal of therapy was palliation and intraluminal irradiation was successful in the prompt relief of obstructive symptoms in the majority of patients. As external beam irradiation alone seldom relieves airway obstruction,³ we currently feel it is inadequate therapy for patients with symptomatic malignant airway obstruction.

Laser resection, as reported by several institutions, is equally effective, however, is technically more difficult especially in cases in which the normal architecture of the bronchial tree has been distorted by tumor. Laser resection frequently requires hospitalization and general anesthesia resulting in increased cost and morbidity. We feel it should be reserved for acute life threatening airway obstruction as a result of tumor involving the trachea or main stem bronchi. It is premature to speculate whether this improved capability of relieving bronchial obstruction by either laser resection or intraluminal irradiation will result in significantly prolonged survival. □

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Maternal Serum Alpha-fetoprotein Prenatal Screening for Down Syndrome

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Judith M. Foster, M.P.H.
and Robert L. Goldenberg, M.D.*

Abstract

The relationship between maternal serum alpha-fetoprotein (MSAFP) levels, maternal age and Down syndrome risk factors were studied in the greater Birmingham and North Alabama areas. After adjustment for race and maternal weight, 3.84 percent of women in this study were determined to have Down syndrome risk factors equal to or greater than that of a 35 year old woman with a normal pregnancy. Maternal weight adjustment was of special importance, reducing the number of MSAFP values considered low from 5.12 percent to 3.40 percent. The use of race and area specific medians was also important in the use of prenatal MSAFP screening for Down syndrome affected pregnancies.

Introduction

Prenatal maternal serum alpha-fetoprotein (MSAFP) screening programs have been designed primarily to detect the presence of an open neural tube defect during the second trimester of pregnancy. More recently, MSAFP measurements have also been used to screen for Down syndrome. The primary means of detecting Down syndrome is to perform an amniocen-

tesis and karyotype analysis on women aged 35 or older. This group includes approximately five percent of all pregnancies and 20 percent of all Down syndrome cases. Based on age alone, 80 percent of all Down syndrome cases are excluded from detection. Mercatz, et al.² reported in 1984 that MSAFP levels were lower in pregnancies associated with a Down fetus. This report was followed by others suggesting that the combination of maternal age and MSAFP measurement could detect about 20 percent of the Down syndrome cases in the under 35 year old pregnant population.³⁻⁵

We report in this paper the results of Down syndrome screening by MSAFP measurement in the Birmingham area. Relationships between race and maternal weight are discussed and formulas and table values for Down syndrome risk factors combining age and MSAFP values have been provided.

Materials and Methods

All MSAFP measurements were performed with the Abbott EIA polyclonal assay. Medians were determined from a population of 5994 patients which included 4638 whites and 1356 blacks evaluated between 15 and 21 weeks of gestation. All MSAFP values were adjusted for maternal weight according to Wald et al.⁶

The combined effects of age and MSAFP levels was determined according to the formula in $R/r = a + bs/m^4$, where R = the prevalence of Down syndrome at the mother's chronologic age, r = the calculated risk of Down syndrome for the patient, s = MSAFP, m = median AFP at the patient's gestational age, and

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a and b are constants (-2.12 and 2.48), respectively. Recent reports of studies using this formula have published risk factor tables for easier determination of risk estimates.^{7, 8}

Results

The risk factors for having a Down syndrome affected infant at term as determined by the combined effects of maternal age and MSAFP measurements are given in Table 1. The age-related risk factors were taken from Palomaki and Haddow⁷ and were derived from three separate studies. Using these risk factors and MSAFP MOM's at intervals from 0.24 to 0.85, MSAFP corrected Down risk factors were calculated using the formula given in Materials and Methods. Levels of MSAFP below 0.9 MOM increase the risk of Down syndrome over that related to age alone. The risks approximately double at a MOM of 0.6, triple at a MOM of 0.4 and quadruple at a MOM of 0.3. One useful way to interpret Table 1 is to note the age at which a risk factor of approximately 1 in 386 occurs. This is the age at which the patient has a risk equal to that of a 35 year old woman. At a MOM of about 0.6, this same risk is reached at age 32, at a MOM of about 0.4, 27 years of age and at a MOM of 0.3, 23 years of age.

In this study, a low MSAFP was described as any value less than 0.5 MOM and all other MOM values that resulted in risk factors equal to or greater than that of a 35 year old, i.e., 1 in 386 or greater. Maternal weight adjustment is very important. Before adjustment, 5.12 percent of all MSAFP values were less than 0.5 MOM. After weight adjustment, the number of patients with MOM's less than 0.5 was reduced to 3.4 percent. When all patients with MOM's less than 0.5 were combined with all others having risk factors greater than 1 in 386, 3.84 percent of women in this study would be diagnosed as having low MSAFP values and as being at risk for Down syndrome.

Discussion

The use of MSAFP measurements was first promoted as a screening tool for prenatal detection of pregnancies associated with an open neural tube defect. Such screening programs are commonplace now and in fact, considered by most to be part of appropriate obstetrical care. The use of such programs for the detection of Down syndrome affected pregnancies is more controversial but gaining in use. The problem with the standard approach to genetic amniocentesis and karyotyping for Down syndrome detection is that it is recommended for women aged 35 and over (unless

TABLE 1
Risk factors at term for Down Syndrome as affected by maternal age and low maternal serum alpha-fetoprotein

Maternal Age	Age-Affected Down Risk	Multiples of the Median (MOM)												
		0.25	0.30	0.35	0.4	0.45	0.5	0.55	0.6	0.65	0.7	0.75	0.8	0.85
20	1:1734	1:387	1:438	1:496	1:561	1:635	1:719	1:814	1:922	1:1043	1:1181	1:1337	1:1514	1:1713
21	1:1612	1:360	1:407	1:461	1:522	1:591	1:669	1:757	1:857	1:970	1:1098	1:1243	1:1407	1:1593
22	1:1500	1:335	1:379	1:429	1:486	1:550	1:622	1:704	1:797	1:903	1:1022	1:1157	1:1309	1:1482
23	1:1408	1:314	1:356	1:403	1:456	1:516	1:584	1:661	1:748	1:847	1:959	1:1086	1:1229	1:1391
24	1:1327	1:296	1:335	1:379	1:430	1:486	1:550	1:623	1:705	1:798	1:904	1:1023	1:1158	1:1311
25	1:1250	1:279	1:316	1:357	1:405	1:458	1:518	1:587	1:664	1:752	1:851	1:964	1:1091	1:1235
26	1:1186	1:265	1:300	1:339	1:384	1:435	1:492	1:557	1:630	1:714	1:808	1:914	1:1035	1:1172
27	1:1124	1:251	1:284	1:321	1:364	1:412	1:466	1:528	1:597	1:676	1:766	1:867	1:981	1:1111
28	1:1064	1:237	1:269	1:304	1:344	1:390	1:441	1:500	1:566	1:640	1:725	1:820	1:929	1:1051
29	1:1014	1:226	1:256	1:290	1:328	1:372	1:421	1:476	1:539	1:610	1:691	1:782	1:885	1:1002
30	1:965	1:215	1:244	1:276	1:312	1:354	1:400	1:453	1:513	1:581	1:657	1:744	1:842	1:953
31	1:915	1:204	1:231	1:262	1:296	1:335	1:380	1:430	1:486	1:551	1:623	1:706	1:799	1:904
32	1:794	1:177	1:201	1:227	1:257	1:291	1:329	1:373	1:422	1:478	1:541	1:612	1:693	1:785
33	1:637	1:142	1:161	1:182	1:206	1:233	1:264	1:299	1:339	1:383	1:434	1:491	1:556	1:629
34	1:496	1:111	1:125	1:142	1:161	1:182	1:206	1:233	1:264	1:298	1:338	1:382	1:433	1:490
35	1:386	1:86	1:97	1:110	1:125	1:141	1:160	1:181	1:205	1:232	1:263	1:298	1:337	1:381
36	1:300	1:67	1:76	1:86	1:97	1:110	1:124	1:141	1:159	1:181	1:204	1:231	1:262	1:296
37	1:234	1:52	1:59	1:67	1:76	1:86	1:97	1:110	1:124	1:141	1:159	1:180	1:204	1:231
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40	1:110	1:25	1:28	1:31	1:36	1:40	1:46	1:52	1:58	1:66	1:75	1:85	1:96	1:109
41	1:86	1:19	1:22	1:25	1:28	1:32	1:36	1:40	1:46	1:52	1:59	1:66	1:75	1:85
42	1:66	1:15	1:17	1:19	1:21	1:24	1:27	1:31	1:35	1:40	1:45	1:51	1:58	1:65
43	1:52	1:12	1:13	1:15	1:17	1:19	1:22	1:24	1:28	1:31	1:35	1:40	1:45	1:51
44	1:40	1:9	1:10	1:11	1:13	1:15	1:17	1:19	1:21	1:24	1:27	1:31	1:35	1:40
45	1:31	1:7	1:8	1:9	1:10	1:11	1:13	1:15	1:16	1:19	1:21	1:24	1:27	1:31
46	1:24	1:5	1:6	1:7	1:8	1:9	1:10	1:11	1:13	1:14	1:16	1:19	1:21	1:24
47	1:19	1:4	1:5	1:5	1:6	1:7	1:8	1:9	1:10	1:11	1:13	1:15	1:17	1:19
48	1:15	1:3	1:4	1:4	1:5	1:5	1:6	1:7	1:8	1:9	1:10	1:12	1:13	1:15
49	1:11	1:2	1:3	1:3	1:4	1:4	1:5	1:5	1:6	1:7	1:7	1:8	1:10	1:11

the patient has a positive history) but only 20 percent of all Down affected pregnancies occur in this age bracket. All other Down affected pregnancies occur in women less than 35 years old.

Even though MSAFP screening detects only an additional 20 percent of all Down syndrome pregnancies, this represents a doubling of former detection rates. Most of the requirements for a screening program for Down syndrome detection are the same as for use in ONTD screening. The use of race-specific medians is necessary as is correction of MSAFP values for maternal weight. Three additional points are also important when screening for Down syndrome. First, since the sliding scale of MSAFP cut-offs may fall anywhere between 0.35 to 0.85 MOM, the laboratory must use an assay capable of accurately measuring 10 to 30 ng/ml. Not all commercially available AFP kits are capable of this sensitivity. Second, because marginally elevated MSAFP values are oftentimes repeated, thereby reducing the number of patients having positive screening results, it is tempting to repeat low MSAFP values also. This policy can adversely affect the detection rate for Down syndrome. Because MSAFP cut-offs for Down detection are at the lower extremes for both affected and unaffected groups, a repeat sample will regress toward a higher value regardless of whether the patient has a Down-affected fetus or not.¹ This concept is known as regression to the mean and results in a false sense of improved risk of carrying a Down syndrome fetus. Repeat testing when an initial low MSAFP value occurs is not recommended. Finally, screening programs should report individual

risks. Many of the early reports provided cumulative risks³ while more recent reports use individual risks.^{1, 7, 8} Use of cumulative risks may lead to almost twice as many patients being diagnosed with low MSAFP values without significant gains in detection.¹

The future of prenatal screening for Down syndrome is promising. Recent publications have indicated that measuring serum unconjugated estriol and human chorionic gonadotropin in addition to MSAFP would detect over 60 percent of all Down syndrome affected pregnancies.^{9, 10} Studies are also underway to determine whether screening with MSAFP would be possible during the first trimester.¹ □

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FAMILY PHYSICIAN — BC/BE to join solo internist. Rural community near University of Alabama. JCAH Hospital. 60K, fringes. Early partnership. J. Lammers, M.D., Box 670, Reform, AL 35481. (205) 375-6251.

FULL-TIME FACULTY POSITION: Assistant/Associate Professor of general internal medicine with or without subspecialty qualifications. Tuscaloosa Program, University of Alabama, School of Medicine. EEOC/AA Employer. Contact: MK Kunze, Department of Internal Medicine, University of Alabama, Box 870326, Tuscaloosa, AL 35487-0326. Telephone: (205) 348-1334.

PHYSICIAN OPPORTUNITY — PHP Healthcare Corporation, a leader in healthcare management services, has an immediate need for physicians to staff primary care clinics located in JACKSONVILLE, FL; CHARLESTON, SC; COLUMBUS and SAVANNAH, GA; FAYETTEVILLE, NC; NORTHERN VIRGINIA, and VIRGINIA BEACH, VA. Other potential locations include Orlando and Tampa, Florida. Qualifications are: BC/BE and appropriate state licensure. Our company offers an outstanding incentive pay plan and provides paid malpractice insurance. PHP also offers a pleasant work environment free from on-call coverage with flexible scheduling arrangements. If interested, please call or send C.V. to: Leigh Robbins, PHP Healthcare Corporation, 7044 Northridge Drive, Nashville, TN 37221, (615) 662-1310.

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Stress and the Medical Family

Stress affects everyone today, and sometimes that is good. We humans seem to perform better, are more alert, and accomplish more under some stress. Problems begin to arise when the stress is more than we can cope with, which is the case with some medical families.

Excess stress begins when the pre-medical student is trying desperately to make the grades to be accepted in the medical school of his/her choice, and continues throughout medical school. Studying, passing, and debts add to the stress, and sometimes courtship/marriage can increase the stress. Marriage CAN decrease the stress because "Shared joy is double joy . . . shared sorrow is half-sorrow," but, of course, this depends on the strength of the marriage.

Next comes internship (does it still exist?) and deciding on type and place of residency (will the competition NEVER end?), now complicated by more debt and perhaps children.

Then — joy of joys — the physician is through with training, is ready to start his/her practice, so all is well, and we all live happily ever after! It would be nice if it were like that all the time, but quite often it is not.

Let's face it — our physician spouses have certain personality traits, or they could not have graduated from medical school. They are highly intelligent, highly motivated, intensely competitive, and must make important decisions — sometimes life and death decisions — quickly. They must put their patients first, and that is acceptable to most of us, until we find we are by ourselves too much, or the children never see their physician-parent, or the physician-parent never participates in couple or family activities.

Choosing a location to practice is a minor stress that can be easily overcome if husband/wife/children agree

on the same location, but if not — watch out! Sometimes in-laws enter into the decision, sometimes helping, sometimes not. The nice thing about our mobile society today is that if the family is unhappy with one location, many locations are available to most physicians. We do have many choices — more than most professions.

After a physician and his family have moved to the selected location, practice stresses that influence the physician's family are finding suitable office space and hiring office help, building a practice, collecting debts, paying bills, having enough liability insurance, and, especially now, complying with the myriad governmental regulations pertaining to Medicaid and Medicare. Family stresses that influence each member are the physician's lack of time for participation in family interests and outings, community pressure for spouses and children to be leaders in volunteer groups and for children to be at the academic top of the class, and unrealistic attitudes of expecting the spouse/children to be able to cope with all of these problems virtually alone.

Some of us can — and do — cope most of time and life works out quite well. ALL of us cannot cope ALL of the time and, if we need help, the American Medical Association Auxiliary has published several booklets that might help in different situations. These are "What Every Physician's Spouse Should Know . . . Marriage," "What Every Physician's Spouse Should Know . . . Medical Family Support," "What Every Physician's Spouse Should Know . . . Professional Liability," "What Every Physician's Spouse Should Know . . . Impairment," "What Every Physician's Spouse Should Know . . . Retirement and Estate Planning," and "What Every Physician's Spouse

Should Know . . . The Training Years." These booklets are available from the AMAA, 535 North Dearborn Street, Chicago, IL 60610, at a price of \$3 per copy for AMA Auxiliary members, and \$5 per copy for non-members.

Physician impairment is often the result of stress. Available for Alabama impaired physicians is our own MASA Hotline (205) 263-3947, and the MASA regular telephone (205) 263-6441. The AMA publishes a "Resource Kit on Physician Impairment," available from the AMA for \$20, which contains a "Guide to AMA Services and Resources on Physician Health," "Prescription Drug Abuse," "AMA Publications," "Aging and Retirement," "Stress Reduction/Impairment Prevention in Residency," "State Medical Society Programs and Services," and "Annotated Bibliography of Physician Assistance Program." I bought a Resource Kit, and it is available for anyone who needs it, or any part of it.

If we cannot cope, and the above booklets do not help us, I hope all of us are wise enough to seek professional help while we still are in control. The help is available — all we have to do is ask for it!



Martha Anne

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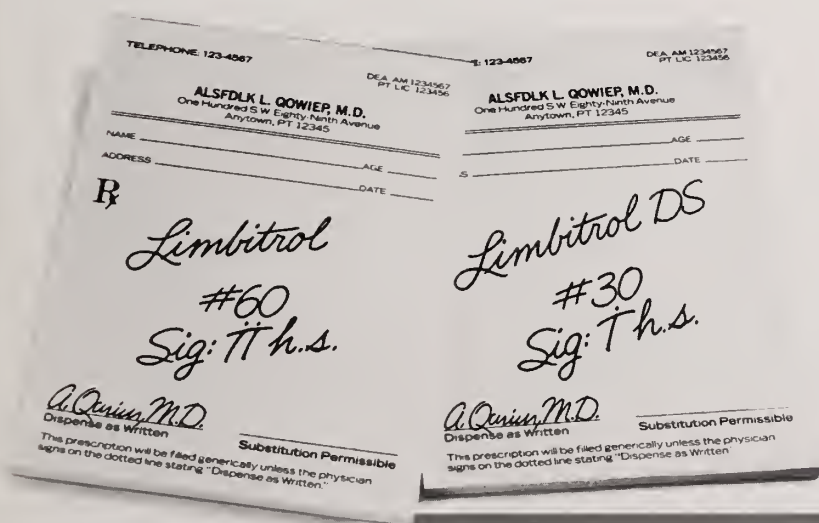
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol[®]

Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 50.

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In the depressed and anxious patient

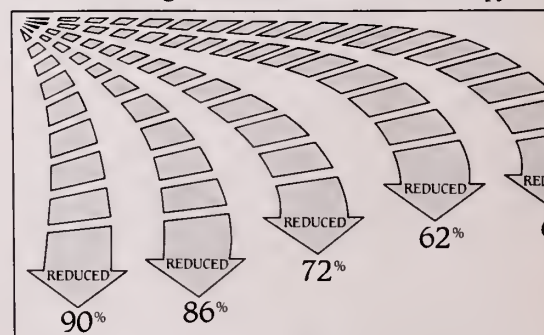
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- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
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Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptom During First Week of Limbitrol Therapy*



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*Patients often presented with more than one somatic symptom.

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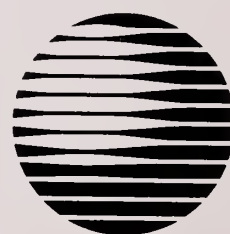


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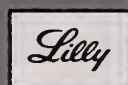
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Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatobiliary syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions – No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (50% weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice given up to 360 mg/kg/day, about 60 times the human dose, and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spinal bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Among placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT/SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H₂-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H₂-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg, respectively.

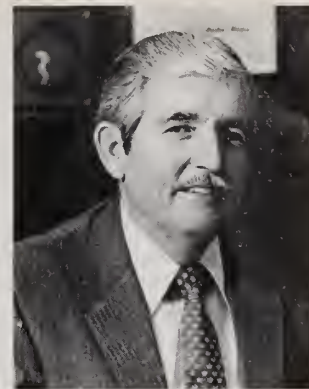
Treatment – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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EXECUTIVE DIRECTOR



S. Lon Conner
Executive Director, MASA

America's Troubled Horizon

It is an article of faith among physicians, I believe, that what is good for the country is good for medicine. Conversely, what is bad for the country is bad for medicine.

Beyond the current trench warfare over the budget and deficit spending; beyond the turmoil engendered by the cost crunch in medicine; beyond the fierce debates among scientists over resource priorities, such as the squabbles between those who favor going for broke on a superconductor/supercollider as against a space station or fusion research; beyond the anguish over the projected cost of the stealth bomber — beyond all this is the over-arching concerns of America's intellectual leadership, in virtually every field, over our impending national decline in science and technology.

Since this country is the only truly benevolent great power in the history of the planet, the shift of scientific and technological leadership to Europe and Asia holds profound implications for us as people and for the world.

Listen to John A. Armstrong, Ph.D., vice president for science and technology at the IBM Thomas J. Watson Center in Yorktown Heights, N.Y.

Dr. Armstrong, 54, did his doctoral research, incidentally, in nuclear magnetic resonance. As chief scientist at IBM labs, he is driven, colleagues say, not alone by IBM's competitive posture in the world markets of science and technology but, above all, by his fears for the decline of his country.

He said in a recent interview:

"I don't think people have any idea how much we are living on borrowed time. Despite all of these discussions about technological competitiveness and who should be investing in what industries, there's a good

chance that . . . in 10 or 15 years it will have all come and gone, because we were not able to gather the technical manpower."

Many Americans were alarmed by the themes in Paul Kennedy's blockbuster, *The Rise and Fall of the Great Powers*, which showed seemingly inevitable historical processes through history that humbled the mighty after a time — Italy, France, Spain, the Netherlands, Great Britain, and so on.

The British-born Professor Kennedy, a former Visiting Fellow at Princeton's Institute for Advanced Study, now holds an endowed chair in history at Yale. His 1987 book jolted the country because it came at a time when his massive scholarship gave substance to thitherto unarticulated fears about American decline. Lest anyone miss his point, he brought it home in his book (on economic change and military conflict from 1500 to 2000) in this fashion:

"Although the United States is at present still in a class of its own economically and perhaps even militarily, it cannot avoid confronting the two great tests which challenge the longevity of every major power that occupies the number one position in world affairs: whether, in the military/strategical realm, it can preserve a reasonable balance between the nation's perceived defense requirements and the means it possesses to maintain these commitments; and whether, as an intimately related point, it can preserve the technological and economic bases of its power from relative erosion in the face of the ever shifting patterns of global production. . . ."

It is the second of these to which this column is addressed. It should be obvious to nearly everyone that America is losing its technological edge in the

world. Much of this decline, critics say, can be attributed to the relatively recent phenomenon whereby corporations and their shareholders are far more interested in short-term profit than long-term growth. Result: R&D investment has dropped drastically in recent years. Mergers and junk bonds seem to hold more fascination among investors than new products that may take years and a lot of money to develop. America's chosen way of late is to let Japan, Italy, Taiwan, China, Great Britain or Canada build it. We market it. Some say this trend really began years ago when RCA and GE decided to quit building TV sets, putting their name on Asian ones instead.

T. Boone Pickens, the Texan tycoon and corporate raider, has turned this inside-out recently. On the sly, he became the largest single shareholder in an important Japanese company. He appeared at a shareholders meeting in Japan in July to berate the company for putting too much of its earnings in long-term R&D. That discriminated against such shareholders as he, interested only in short-term profits, he said.

I would like to join those who believe Mr. Pickens had his tongue in check, because what he criticized the Kiota Manufacturing of Tokyo's management for is the precise reason Japan is outstripping American industry on so many fronts — long-range planning and development.

But let's suppose that the hand-to-mouth binge is ending in America, that having wallowed for many recent years in fast-buck materialism, we are about ready to return to the manifest destiny of a country that invented and built just about everything. Assuming such a massive about-face in traditional work values and ethics, could we do it again?

Dr. Armstrong seems to doubt it. We simply don't have the manpower. Our schools are nowhere near the quality and intensity of those in Japan and Germany; our children are probably the least informed and least highly motivated of any advanced industrial society. And the demographics suggest it is going to get worse, much worse.

The National Science Foundation (NSF) weighed in a few weeks ago with its forecast: a shortfall of 675,000 scientists and engineers by the year 2006, which is no further in the future than 1972 was in the past. There are other changes, many other changes.

NSF noted that white men now make up 47% of the U.S. work force, and 80% of the science and engineering work force.

But, according to *Science* for June 30, these white males will constitute only 15% of the 25 million people entering the workforce in the last years of this century.

By 2010, *Science* says, they will make up less than one-third of the college-age population.

Before you charge NSF or me with racist male chauvinism, consider the facts: women and minorities are not following in white male footsteps in the physical

sciences (although they are becoming better represented in the life sciences, health, etc.).

Thus American science and industry must try to entice women, white and non-white, and turn to immigrant men and women, to try to replace the disappearing white male.

A major cause of this impasse, of course, is the relatively low birth-rates of middle and upper-class women in the U.S. Richard J. Herrnstein of Harvard has been abused as a racist (naturally) for his learned observations lately that the U.S. population is growing by a kind of eugenics in reverse, with the lower IQ groups reproducing rapidly while the higher IQ couples remain childless.

The babies born to lower socioeconomic classes are short-changed by more than heredity, of course; the environment of poverty and single-parent families does not produce scholars in any great abundance.

Although non-white babies now represent one in five births, twice that ratio are born to families with incomes of less than \$10,000. He rests his case on a "correlation between social status and intelligence" and on his belief that an individual's potential productivity is heavily influenced by genetics.

Even if it weren't, he says, the higher birth-rate of the economically disadvantaged would insure serious environmental deficits. Thus, he holds, both nature and nurture are reducing the nation's collective intelligence.

You have perhaps seen national news accounts of nationwide shortages of teenagers to fill traditional jobs this year.

The shortfall may be attributed in some measure to a preference for indolence, but demographers believe this is an early warning of the "birth-dearth" generation which followed the baby boomers.

Like a pig in a python, to use the demographer's indelicate figure of speech, this dearth will move right on through to produce the shortages at the higher levels of science and industry.

Couple that shortfall with the fact that such a large number of those who *are* available for employment now and will be in the future are from the lower economic groups to which Dr. Herrnstein has addressed his concerns over "the correlation between social status and intelligence," and it is easy to see the beginnings of a truly critical shortage of qualified replacements for the scientists and engineers who will be retiring in the critical years ahead.

There are so many ramifications and permutations to this enormous problem, surmounted by so many possibilities for the conventional hue and cry of "racism," that many worried scholars close to the studies despair of a renaissance, a massive national rededication to excellence.

Yet nothing less than the future of the United States is at stake. Since physicians are numbered among the

present intellectual elite of the country, and the future of their profession is imperiled as well, I believe you must assume leadership roles in the indispensable reforms that must come, in virtually every area of our national life, certainly beginning with overhauling public education and reasserting the primacy of excellence in all fields.

First to go, in my judgment, must be the misplaced and benighted egalitarianism that condemns as "discriminatory" the very intellectual elitism that made this country great.

Otherwise, your children and grandchildren may live in a national in abject decline from the 20th century heights of achievement, benign power and leadership. □

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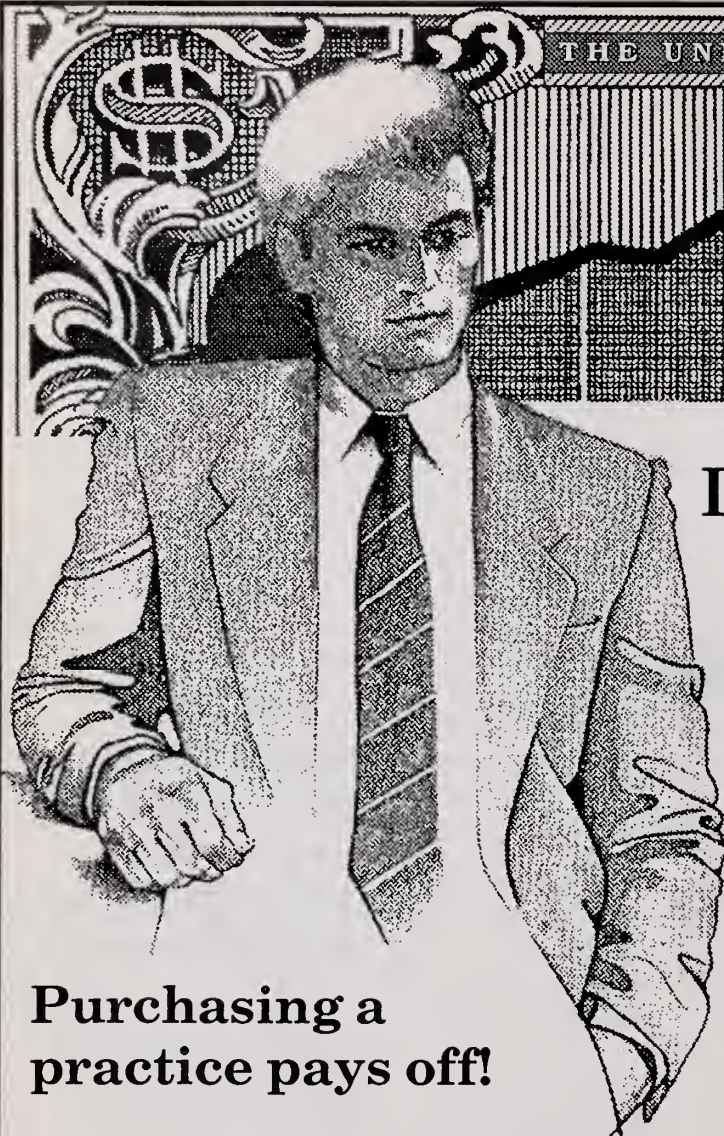
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*Burt Taylor, M.D.
President, MASA*

AMA: Watchdog and Friend

The American Medical Association needs you!

I believe you need the AMA. The AMA serves as an alert "watchdog" in Washington every day. The various representatives of the AMA try to improve the environment in which we practice medicine. It is a constant battle. I believe they are doing an outstanding job.

The leadership of the AMA cannot do it alone. They need the support of each physician. Some of us simply have not done our part. Maybe it is because we really do not understand the intricacies of such a massive organization.

Getting to know so many physicians from across our entire state I have become aware of the really outstanding men and women that make-up the Medical Association of the State of Alabama. It seems absolutely necessary that all of these dedicated and hard working individuals pull together to protect the lofty position of American medicine.

Any team is only as good as the individual players and to keep any organization strong and moving forward there must be a constant infusion of quality people. This is a vital for our State Association and the American Medical Association. I have been privileged to participate *actively* in the State Association during the past five years.

Prior to 1985 I was a passive participant. I sent in my dues and expected all of the decisions reached by the active members to agree with my own thoughts, which I kept to myself. I was too busy practicing "good medicine" to participate in "all of that non-medical stuff."

One thing stands out crystal-clear. Physicians have strong egos and form uncompromising opinions. We

must be convinced by sound reasoning, rather than force, that we might need to reconsider our original position on any given subject. Unfortunately, we are not always provided with all of the necessary information about any given issue. Obviously, it becomes impossible to consider all of the various options fairly. Frequently, many of us will make a firm decision without all of the facts. This usually leads to heated debate and bruised egos.

When the AMA dues request arrives in October, many of us simply discard it without further consideration. So many of my colleagues approach me during the year with the same comments and questions:

"Burt, I don't like organized medicine. I just like taking care of my patients."

"Why should I belong?"

"They take my money and don't do anything for me."

"I don't agree with the activities of the AMA."

"They really don't represent me."

"The AMA really cannot do anything."

"The AMA is too liberal."

"Why bother?"

The American Medical Association meets in June each year in Chicago, Illinois. There is an interim meeting in December, which takes place in various cities across the nation. During the past two years I have had the opportunity to attend these meetings. I certainly did not understand the many activities and I had the same doubts and reservations that anyone might have had while standing aside observing a large organization from a distance.

I was concerned about the leaders and the delegates. I was worried about the size of the organization and

the opportunity for the individual delegate to be heard. The delegates and leaders are men and women just like each of us. They give their time and they do an excellent job in a democratic manner. Each delegate *can be heard*. I can report to you that this is a viable, responsible and necessary organization.

The AMA was founded in 1847 as a nonprofit public service institution. Its avowed purpose — "To promote the science and art of medicine and the betterment of public health." Incidentally, only Selma and Mobile had organized medical societies in 1846. On December 1, 1847, 21 physicians met in Mobile County. They adopted a constitution, elected officers, and declared themselves the Medical Association of the State of Alabama. The first regular meeting of the State Association was in 1848. That same year 10 members represented Alabama at the Baltimore meeting of the recently formed American Medical Association.

The AMA House of Delegates is the national policy-making body of the medical profession. Representatives from state medical societies are elected on the basis of one delegate for each 1,000 active members, or a portion thereof, in the State. Therefore, Alabama has five delegates to the American Medical Association.

During the period between meetings of the House of Delegates, the AMA is governed by the Board of Trustees composed of the President, President Elect, immediate Past-President and 14 Trustees elected by the House of Delegates.

The programs established by the House of Delegates are carried out by the AMA staff. There are over 1,000 staff members headquartered in Chicago, with a large contingent of personnel assigned permanently to Washington, D.C.

Can you imagine trying to represent all of the physicians of the State of Alabama? The young physicians certainly have many interests and worries as they look into their future. Those physicians nearing retirement have a different perspective. The female-male ratio is constantly changing. Many Alabama physicians have problems that are related to their practicing in rural areas. The physicians in the cities of Alabama have entirely different needs. Some of us are more conservative than others. All specialties must be represented equally. It is a tremendous responsibility.

We have a very strong AMA delegation. I have spent many hours with them as they prepare for our meetings. Any physician may speak before a Reference Committee at the time of the AMA meeting. If you have a resolution it would have to be brought to the floor by one of our delegates. Certainly, they would welcome an opportunity to talk with you and see if they could support your resolution and present it to the AMA House of Delegates.

Each Alabama delegate serves for two years. They are elected at our annual session in April. There are

no restrictions regarding the number of times that a delegate might be re-elected. Additionally, there are five alternate delegates attending each AMA meeting. As the result of the elections at our annual session in April, 1989, the following is a list of delegates and alternate delegates that will be in place as of January 1, 1990:

DELEGATES:

1. Julius Michaelson, Foley, Family Practice
2. William H. Cooner, Mobile, Urologist
3. William A. Leitner, Birmingham, Urologist
4. William T. Wright, Mobile, Family Practice
5. Jon E. Sanford, Fayette, Family Practice

ALTERNATE DELEGATES

1. Edgar W. Branyon, Anniston, Radiologist
2. Carl A. Grote, Huntsville, Family Practice
3. W. Earle Riley, Birmingham, General Surgeon
4. Kenneth C. Yohn, Eufaula, Family Practice
5. Garland Hall, Moulton, Family Practice

There were 435 delegates seated at the 1989 Annual Meeting of the House of Delegates. There were 347 delegates representing the various State Medical Associations, 78 delegates representing the national medical speciality societies, 10 section and service delegates representing medical students, medical schools, resident physicians, and others.

During each session, one will see all resolutions receiving thorough discussion at the appropriate Reference Committee followed by a lively debate before the House of Delegates.

Your AMA delegation truly wants to represent the Alabama physicians and do what is best for our state. They need your input. They are good listeners. You should communicate with them before the June and December meetings. Please remember these men donate their time away from their practices. They receive reimbursement for their expenses only.

We are planning to have the Alabama delegates present some of the major topics of the AMA during the next session of the State Association meeting in April. I think it would be very informative and I am sure they would welcome your questions. It would be a good opportunity to meet your representatives and get to know them.

Perhaps the major activity of the American Medical Association is the constant monitoring of proposed federal legislation which leads to guidelines, regulations, and laws. Numerous far-reaching proposals are being introduced to the subcommittees and committees of the Senate and the House regularly. Many of these affect us directly and indirectly. Some will "pop up" suddenly at a later date. The actively practicing physician will simply not be aware of this legislation until it has become law.

continued on page 12



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Representatives of the AMA regularly attend the various committee and subcommittee hearings that pertain to health care. We have well qualified representatives who testify regularly. Similar to all of the other major organizations in our nation, we have a strong lobby which must be maintained in Washington, D.C.

The day after the recent AMA annual session our Executive Vice-President Dr. James Sammons, the AMA president, and several others flew to Washington to testify against the proposed expenditure targets. These targets will be unworkable and unfair in actual practice. The *Government*, not the medical profession, will establish the targets. These targets cannot be established scientifically, either before or after the services are provided. They will inevitably be arbitrarily low as health care spending competes with other government priorities. This is just a single example of the ever-changing environment which we must continue to monitor to ensure quality medical care.

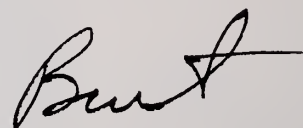
Only approximately 44% of American physicians are members of the AMA. At the same time the AMA

is always working for *all* of the physicians in America. One can only imagine the additional problems we would encounter without the benefit of the AMA representatives meeting with our congressmen and appearing before the various committees and subcommittees.

As I mentioned earlier, we will be receiving our AMA dues request in October. Certainly, I would hope that you will continue to participate. It would be nice if you could talk to some of your friends who are not in the AMA and are taking a "free ride." Ask them to join you and others to assure a dialogue will continue and that physicians will have input into the never ending edicts from Washington.

The dues for physicians in their first year of practice are \$200. The second year in practice dues are \$300. For the remainder of us it will be \$400 annually.

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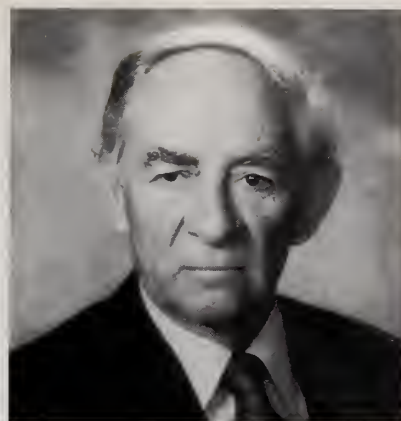
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Claude L. Brown, M.D.

Seascapes

The New Orleans Lightship, the offshore marker for the channel cut through mud flats to the Mississippi River, was located 50 miles south of the Mississippi Coast, 15 miles east of the delta.

We had been sailing eight hours downwind in an ever-strengthening blow; it was April 1, and a hard northerner had been blowing for 24 hours. "These northerners usually die down after sunset," we had told each other. Sometimes they do, but this one was breathing fresh life hourly. Running at full speed, the boat was not hard to control. We had eaten steak sandwiches with cake and peaches for dessert, washed down with coffee, before sundown.

Even though it was blowing 30 knots, with air temperature of 50 degrees, our down-wind course let us stay relatively comfortable. As a following sea swept beneath the hull with increasing frequency, the stem would rise, then descend, as the sea hissed and foamed away. One cannot resist the urge to flick on the spotlight for a view of such seas; unless one is a brave soul, it is best not to do so, however — the picture is intimidating. Literally, a situation in which you do not want to look back, for something quite threatening is about to catch you, and does.

With combers crashing on her bulwarks and decks, the bow of the Lightship rose and plunged 10 feet as we sailed by her port side. At exactly midnight, we trimmed our sails and steered *Dundee* to windward around the stern of the Lightship; I knew then we were in trouble.

The extent of our problems became quickly apparent. Now heading into the wind and waves, our speed dropped to 4 knots, and occasionally the speedometer needle fell to zero. The latter happened when the stem of the boat butted into the side of an oncoming sea instead of riding over its crest. With incalculable energy, the water exploded over the fore deck; spray drenched the mainsail up the spreaders, blinding and drenching us in the cockpit; and, with the hull so far down in a trough of the sea, the sails shuddered, wind-

less for a second.

The noise, of course, was deafening. Even if you stand motionless in a 35-knot wind, the anatomy of your ears produces considerable noise. We were not standing calmly in an empty field: there was the blasting wind, the hum of the rigging, the sound of the sea itself in its fury, and the heavy concussion of the boat hitting a wave or dropping off one.

Plus, shortly, the sound of our retching, which was miniscule compared to the other noises. All of us became horrendously seasick, and such seasickness is demoralizing. Soon there was nothing to emit, so we retched. We were freezing, also. Any movement was a severe effort of both will and muscle. Two of us would remain on deck — one at the helm, the other trimming sails. The other three huddled in the cabin which was slightly warmer, being out of the wind, but more frightening because of the optical illusion of increased motion in a smaller space, and the closer proximity to the sounds of the hull slamming into the seas. We were in survival conditions, and I was uncertain of the outcome. As skipper, one is responsible for the crew, but I knew that I was incapable of much responsibility for anything.

The worst night of my life was going to be the longest. Our course was the only reasonable one to sail, and it was dead to windward. I thought of the catastrophes that could occur — man overboard, being run down by a ship, a dismasting due to the forestay snapping — but the immediacy of staying drenched constantly, shaking with cold and moving with the utmost care took precedence over my imagination. I did not need to fantasize dangers when the palpable ones were overwhelming. We were intact, the crew and the boat, but only passive participants.

But this was not true! The boat, at least, was fighting gamely, and I had to admire her struggle. After a sea smashed under her she descended into the trough with a rush that was terrifying — her bow was pointed downward 45 degrees and when she reached the bot-

tom of this foaming valley she stopped. Every time she recovered, caught her breath and began to climb the next sea.

Gradually I came to be heartened by this performance, and slowly I began to think that I was receiving some great message. The message was that, if we continued our present activity we might be all right. In short, we should "carry on": A term derived from the sailing ships meaning that the vessel would "carry" as much sail as deemed proper. We must continue the effort; we had the example of *Dundee*, herself, to cheer us. Salvation consisted of enduring. To be sure, there was no promise of this salvation but there was a possibility, and perhaps when daylight came we could think of probability.

This awareness must be one of mankind's most valuable concepts. Expressed in a multitude of images, the ineffable worth of doing what must be done, handling the day's tasks as best possible, "staying the course," is occasionally lost by becoming, or remaining, only an intellectual idea. An integral feature of thoroughly "knowing" anything is the transposing into action some feature of what is known; it is only then that we possess the truth of an idea, and can assess its merit. During that awful night I was not philosophizing but I did know that a magnificent gift had made itself felt somewhere in my frigid, frightened interior.

Except on rare occasions the sea, unlike the land, is never black-dark. Starlight was sufficient to show us the roaring, white-topped wall of water that repetitively bore upon us, tossed *Dundee* up, hurled her down, half filled the cockpit and half drowned us. All thought, like all action, was limited, slow and feeble. But I did think of the night ending; I infrequently thought that every minute brought us closer to dawn, and to land. Two crewmen thought they would never see daylight, that they would die shortly, and I rather believed them. Henry, Ed and I estimated that since we had lasted this long, we would probably die of hypothermia by daybreak. (I have come to think of hypothermia as a mythic entity. How many hands died on a Cape Horner of hypothermia?) We hoarsely gasped a few words, "Sun up at 6 A.M.," and I noticed that I kept looking eastward.

Very gradually the light increased. I now know that the anonymous cynic meant when he said that it was always colder and the seas were always bigger just at first light. We yearned for the sun as the infant yearns for the face of its mother. It an age-old urge of mankind to dispel the terrors of the darkness by light, to be able to see the reality that surrounds us and to take some comfort from perceiving definite friendly figures rather than ambiguous shadows. When the sun did rise it replaced the ominous shadows and shapes of the half light with a spectacle even more appalling.

For we now saw, extending to the horizon in all directions one of the recurring natural wonders of the

world: the face of the sea in a sustained gale. I thought of the passage in *Moby Dick* where Ishmael, after long waiting for the appearance of Captain Ahab about whom he had heard such morbidly fascinating stories, finally catches his first sight of the master:

Reality outran apprehension; Captain Ahab stood upon his quarter deck.

The wind had veered 35 degrees, with the waves eventually following suit, so instead of being dead to windward we were meeting the seas more on the starboard bow. At a height of 12 to 15 feet the rollers were about 200 yards apart, their crests not being blown off by the wind but rather curling and breaking.

The situation differs from viewing the Grand Canyon, or Victoria Falls, for the sea is alive and in our boat we were participants in a tremendous process. We were a part of this prodigious force, this massive display of power. Although palpably incapable of opposing the gale, we could exert some direction, could guide ourselves a bit, and were surviving in the midst of immense turbulence. Our position, sickening and frightening, was also exhausting and gratifying.

Having paid the price of admission, I was allowed to see two features of the ocean, one of which I have never heard or read described although both undoubtedly have been observed by seamen forever. The one "unknown" to me involves color: if you are in just the right spot (and this is reached by being in a small boat to leeward of a large enough wave that has the sun behind it) you can see the sunlight shining through the top foot or so of the wave crown with a glorious golden hue. This brilliance increases, from the bottom of its visibility to the top of the crest where, due to the evanescence of the wave, all color vanishes abruptly with the breaking of the sea. This spectacular pattern lasts only a short while until the sun rolls higher.

The other impressive phenomenon concerns sea foam, which, even though Aphrodite supposedly sprang perfect from its insubstantiality, is but the whitish mix of air and water. When one of the long ridges reared up to its summit, curled and crashed foaming to leeward, there would suddenly appear an area, entirely white, covering half an acre — an enlarged whitecap. Poised briefly in a wave summit, I could see many such cottony fields suddenly blooming and slowly dissipating on a grey heaving surface.

The wind and sea gradually lessened, and as the warmth increased the near-dead staggered on deck and slowly resumed a wider consciousness.

A severe exterior passage can be the occasion for a searching interior journey — as was the case with us. We ventured to some extremes of feeling and observation that were quite unforgettable. New perceptions of ourselves were distilled from this amalgam of ignorance, humility, fear and struggle with magnificent forces.

What more could I wish?





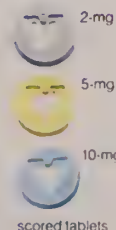
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The Edna Merle Carraway Convention Center —
Birmingham**

Purpose of the Program — This program is designed to allow Alabama physicians to share with their colleagues current research efforts and professional concerns. Topics selected will cover a wide range of medical interests.

Program Format — The program will be structured from the papers submitted by Alabama physicians. Time will be scheduled for questions. Registrants and participants will receive advance copy of all papers.

Paper Selection — Papers will be selected using the following criteria and procedures.

1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written materials to be used with the presentation for the study and use of the attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interest to offer a balanced program of general interest.

Symposium Timetable . . . August 15 to October 15, 1989 — Call for abstracts. October 15, 1989 — Final date for abstracts to be received. Late October, 1989 — Review of abstracts by the Council on Medical Education and final selection of papers. November-January 1990 — Announcements of selections; publicity and promotion of Symposium, printing of abstracts and handouts. January 20, 1990 — Program in Birmingham.

Symposium Topics — To acquaint potential presentors with the kinds of subjects that might be suitable, the speaker and topics at the 1989 Symposium are listed below.

Max Michael, M.D. — **Mohammed's Mountain-Delivery of Health Care to Homeless People**; Robert Pieroni, M.D. — **Digitalis Toxicity**; Ruby Meredith, M.D. — **Advances in Hyperthermia for Control of Cancer**; Steven Stokes, M.D. — **Intraluminal Irradiation for Obstructing Endobronchial Carcinoma of the Lung**; Cynthia Lorino, M.D. — **The "Abnormal" Breast; Biopsy Is Not Always Necessary**; Rudolph M. Navari, M.D. — **An Overview of Bone Marrow Transplantation**; Howard C. Snider, Jr., M.D. — **A Surgeon's Encounter with the Malpractice Crisis**; Robert L. Baldwin, M.D. — **Tinnitus-An Old Nemesis: Evaluation and Treatment of the Problem Case**; Richard W. Waguespack, M.D. — **Current Concepts in the Management of Sinus Disease**; John Gerwin, M.D., et al. — **Evaluating the Patient with Hoarseness — A Clinical Guide**; Paul S. Howard, M.D. — **Body Sculpting with Suction Assisted Lipectomy: Is It Safe and Does It Work?**; David Montiel, M.D. — **Outpatient Angiography: Two Year Retrospective Review**; Zenko Hryniw, M.D. — **Current Diagnosis and Treatment of Lumbar Disc Disease**.

Abstracts — Abstracts of the proposed paper (200-300) words, double-spaced) should be sent to the Council on Medical Education, using the form below, or a similar format.

ABSTRACT

TO: Council on Medical Education, MASA, P.O. Box 1900, Montgomery, AL 36102

I would like to present a paper at the MASA Invitational Symposium on Saturday, January 20, 1990 at the Carraway Convention Center in Birmingham. An abstract (200-300 words doubled-spaced) is attached.

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Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E. B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged. Second Edition.

Length of articles: Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

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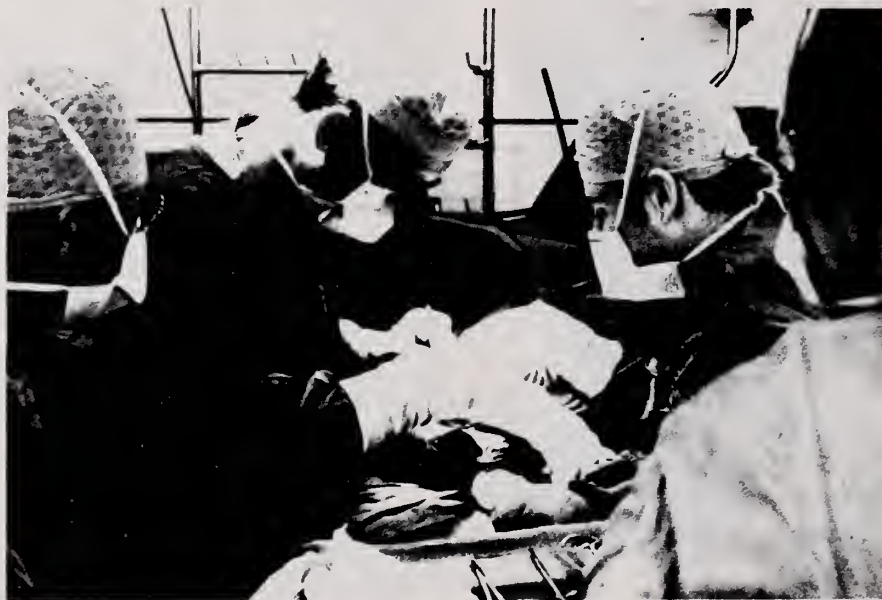
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Chicago 1989 Revisited

Representing A-MASA at the Annual Convention of the American Medical Association Auxiliary in Chicago June 17-21 were immediate past State President Marlynn Rhyne, State President Martha Anne Hardiman, President-Elect Antoinette Patterson, and delegates that the members elected in Tuscaloosa in April: Julie Curry of Carrollton, Carolyn Fritz of Tuscaloosa, Terry Glasgow of Birmingham, Nadia Longmire of Russellville, and Margaret Mitchell of Sheffield. Also in Chicago from A-MASA were National Past President Belle Chenault of Decatur, and National Board Member Ebbe Dunn, Director, Southern Region, of Wetumpka.

Ebba had to be in Chicago early for Board meetings, but the rest of us arrived on Saturday, June 17. Margaret and I flew from Muscle Shoals, Belle and Nadia from Huntsville, and the majority of the group flew from Birmingham. We had dinner early Saturday night at the Cape Cod Restaurant in the Drake Hotel, so we could retire early to be ready for the strenuous days ahead.

Meetings started promptly at 8:30 Sunday morning, with a video preview of "A Message from the 1989-90 Auxiliary President," Jean Hill (Mrs. J. Edward), from Mississippi, and highlights of outstanding Auxiliary Projects. Immediately following, guest speaker John Zapp, DDS, Director, Division of Government Affairs, AMA Washington Office, talked on "Legislative Issues and Concerns — Update 1989," with presentation of facts and figures about Expenditure Targets, which to most physicians means a rationing of services for patients.

Committee Breakout Sessions were AMA-ERF, Health Projects, Legislation, and Membership, with our delegates assigned by me to specific session, so

all would be covered. (I did suggest that delegates might swap sessions, if interest in one committee was greater than interest in an assigned committee.) Some reports from delegates will be in our Fall A-MASA News on different aspects of the meeting.

I attended the Health Projects meeting with Terri Glasgow, and we were told that in August I will be sent a 55 minute Video made by the American College of Obstetrics and Gynecology on Adolescent Health, with a study guide. We have permission to copy this tape, and we will do so if counties wish to use it after we have previewed it at our Fall Workshop at the Wynfrey in Birmingham on September 12, and 13.

After a salad bar buffet luncheon at The Drake, we rushed over to the Chicago Hilton Hotel for the Opening Session of the AMA House of Delegates, where our AMAA outgoing President Mary Strauss (Mrs. Albert J., Jr.) presented a check representing the Auxiliary's AMA-ERF contribution of \$1,872,247.91 to Lonnie Bristow, M.D., President of the American Medical Association Education and Research Foundation. AMA presented several awards, including four Citations of a Layman for Distinguished Service. One of these was presented to former First Lady Betty Ford, who was most gracious in her acceptance of this award.

Dashing back to the hotel, we barely had time to change clothes for the 5 P.M. opening meeting of the 66th Annual Session of the House of Delegates of the American Medical Association Auxiliary. This is an impressive ceremony with the Presentation of Colors by the U.S. Army Color Guard from Fort Sheridan, Illinois, and the presentation of each of the newly installed Presidents of the 50 state auxiliaries. When your state president was presented, it was announced that Alabama had over 75% unified membership, and

President-Elect Antoinette Patterson answered the roll call at the microphone on the floor with the eight delegates from Alabama standing.

Keynote speaker was the Honorable Lynn M. Martin, member of the House of Representatives from the 16th District of Illinois. She was an excellent speaker, and encouraged physicians and their spouses to become involved in political activities in some way, from just knowing enough about what is going on in Washington in order to vote intelligently to running for a legislative or other political office so medicine can have an input into its own future.

At 7 P.M. a reception for Mary Strauss, President, and Jean Hill, President-Elect, was held in the Gold Coast Room of the Drake Hotel. The receiving line was long, the decorations were lovely, and the food was scrumptious, including soup, beef, chicken, ham, fish, vegetables, fresh fruits, cheeses, and nuts.

Monday had an auspicious beginning at 7:30 A.M. with a continental breakfast sponsored by AMPAC, with our own Belle Chenault presenting the "Belle Chenault Award for Political Participation" to Becky Smith, auxiliary member from Broward County, Florida. This award, given by AMPAC to an active AMPAC member from nominations made by State PACS, was named in honor of Belle by the AMPAC Board because Belle has served on the AMPAC Board, and has set an example for us by being politically active.

Work sessions today were Reference Committee Hearings on Bylaws, Organization Affairs, and Health Issues. Luncheons honored AMA Auxiliary Past President and Honorary Members, with Ellen Goodman, Syndicated Columnist, as guest speaker. Monday afternoon nominations for the 1990 Nominating Committee were made, with Ebba Dunn being on of two nominations from the Board of Directors. Reports of AMA-ERF and Membership Committees, and report of Southern and Eastern State Presidents, with presentation of AMA-ERF and membership awards were next. Marlynn Rhyne's report on Alabama was excellent, and in her two minutes allotted time she told of Madison County's organ donation project, which reached over 1,000 16-year-olds this past year, and of Alabama's contributions to the Metal Implant Bank. Alabama received an award for starting a new Auxiliary — Cullman County. Every Southern State received at least one award!

Tuesday our delegation met in my room at 7:45 A.M. for a continental breakfast while we had a caucus to discuss Reference Committee Reports that I had picked up at 7:15. Belle and Ebba joined us to help us with our decisions. The General Meeting started at 9, and reports were given by the Reference, By-Laws, Long Range Planning, Health Projects, and Legislation Committees. Then two-minute reports from North Central and Western State Presidents, with AMA-ERF and membership awards presented. Guest speaker at

luncheon was Willard Scott, weather reporter on NBC News' "Today" show.

Immediately after lunch the official delegates voted, and then a special session was held on "Assets and Liabilities of Working in Your Spouse's Office." Some of us took a few minutes for some quick shopping after voting, while some attended this meeting.

The last General Meeting started at 9 A.M. Wednesday morning, with James E. Davis, M.D., President, AMA, Lorre Lei Jackson, member, AMPAC Board of Directors, and Lonnie Bristow, M.D., President, AMA-ERF, as our special guests. M. Donald Weston, M.D., Chairman-Elect, AMA Section on Medical Schools, was our speaker. He stated that regardless of what we read or hear, most physicians uphold the Hippocratic Oath, and are compassionate, caring people. We spouses certainly agreed.

The Election Committee made its report, and we were happy to learn that Ebba Dunn had won a place on the Nominating Committee for 1990. Glenda Bates (Mrs. John G.) of Georgia, National Past President, 1983-84, installed the officers for 1989-1990, and Jean Hill (Mrs. J. Edward) of Mississippi made her inaugural address. We were adjourned to return home weary but enthusiastic about our Auxiliary and the help that is available to us from our national and district officers, our new publications, and the national office and staff.

Martha Anne

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Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. It is symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General:* *Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Osmotic reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy - Category C: There was no teratogenicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of 14 C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (1.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category.

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances: atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine ≤ 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg q.d. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine > 16 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d. then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more. If at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function, the maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19386. J6V518R21817

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Alabama Medicine

September 1989

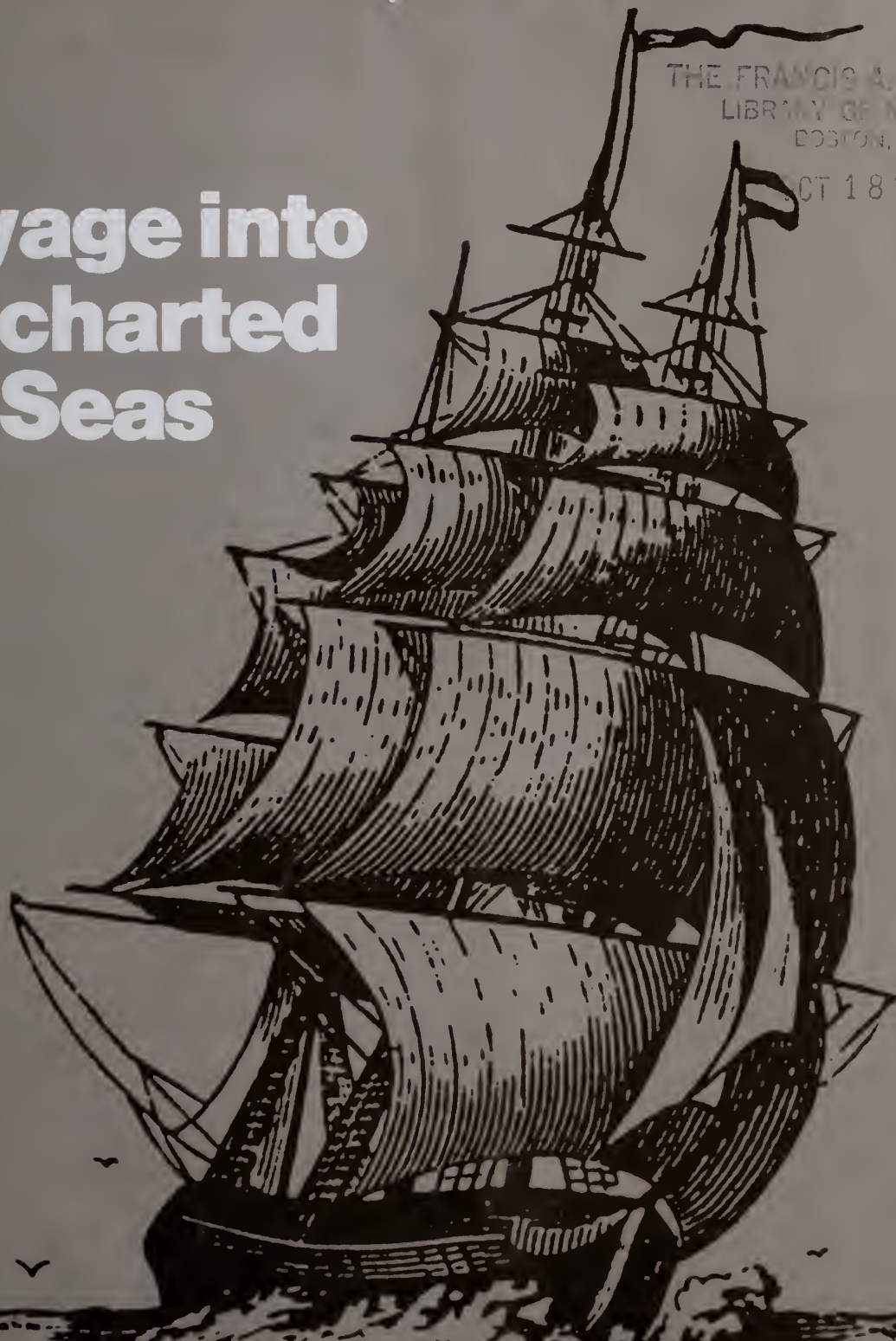
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Our Belle

From Route 16...



CODEINE
COMBINATIONS

to Room 16

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DESCRIPTION

Meperidine hydrochloride is ethyl 1-methyl-4-phenylisonipicoate hydrochloride, a white crystalline substance with a melting point of 186°C to 189°C. It is readily soluble in water and has a neutral reaction and a slightly bitter taste. The solution is not decomposed by a short period of boiling.

The syrup is a pleasant-tasting, nonalcoholic, banana-flavored solution containing 50 mg of DEMEROL hydrochloride, brand of meperidine hydrochloride, per 5 mL teaspoon (25 drops contain 13 mg of DEMEROL hydrochloride). The tablets contain 50 mg or 100 mg of the analgesic.

DEMOROL hydrochloride injectable is supplied in Carpuject® Sterile Cartridge-Needle Unit of 2.5% (25 mg/1 mL), 5% (50 mg/1 mL), 7.5% (75 mg/1 mL), and 10% (100 mg/1 mL). Uni-Amp® Unit Dose Pak—ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Uni-Nest™ Pak—ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Multiple-dose vials of 5% and 10% solutions contain metacresol 0.1% as preservative.

The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid.

DEMOROL hydrochloride, brand of meperidine hydrochloride, 5 percent solution has a specific gravity of 1.0086 at 20°C and 10 percent solution, a specific gravity of 1.0165 at 20°C.

Inactive Ingredients—TABLETS: Calcium Sulfate, Dibasic Calcium Phosphate, Starch, Stearic Acid, Talc, SYRUP: Benzoic Acid, Flavor, Liquid Glucose, Purified Water, Saccharin Sodium.

CLINICAL PHARMACOLOGY

Meperidine hydrochloride is a narcotic analgesic with multiple actions qualitatively similar to those of morphine; the most prominent of these involve the central nervous system and organs composed of smooth muscle. The principal actions of therapeutic value are analgesia and sedation.

There is some evidence which suggests that meperidine may produce less smooth muscle spasm, constipation, and depression of the cough reflex than equianalgesic doses of morphine. Meperidine, in 60 mg to 80 mg parenteral doses, is approximately equivalent in analgesic effect to 10 mg of morphine. The onset of action is slightly more rapid than with morphine, and the duration of action is slightly shorter. Meperidine is significantly less effective by the oral than by the parenteral route, but the exact ratio of oral to parenteral effectiveness is unknown.

INDICATIONS AND USAGE

For the relief of moderate to severe pain (parenteral and oral forms)
For preoperative medication (parenteral form only)
For support of anesthesia (parenteral form only)
For obstetrical analgesia (parenteral form only)

CONTRAINDICATIONS

Hypersensitivity to meperidine.

Meperidine is contraindicated in patients who are receiving monoamine oxidase (MAO) inhibitors or those who have recently received such agents. Therapeutic doses of meperidine have occasionally precipitated unpredictable, severe, and occasionally fatal reactions in patients who have received such agents within 14 days. The mechanism of these reactions is unclear, but may be related to a preexisting hyperphenylalaninemia. Some have been characterized by coma, severe respiratory depression, cyanosis, and hypotension, and have resembled the syndrome of acute narcotic overdose. In other reactions the predominant manifestations have been hyperexcitability, convulsions, tachycardia, hyperpyrexia, and hypertension. Although it is not known that other narcotics are free of the risk of such reactions, virtually all of the reported reactions have occurred with meperidine. If a narcotic is needed in such patients, a sensitivity test should be performed in which repeated, small, incremental doses of morphine are administered over the course of several hours while the patient's condition and vital signs are under careful observation. (Intravenous hydrocortisone or prednisolone have been used to treat severe reactions, with the addition of intravenous chlorpromazine in those cases exhibiting hypertension and hyperpyrexia. The usefulness and safety of narcotic antagonists in the treatment of these reactions is unknown.)

Solutions of DEMEROL and barbiturates are chemically incompatible.

WARNINGS

Drug Dependence. Meperidine can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of meperidine, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Like other narcotics, meperidine is subject to the provisions of the Federal narcotic laws.

Interaction with Other Central Nervous System Depressants. MEPERIDINE SHOULD BE USED WITH GREAT CAUTION AND IN REDUCED DOSAGE IN PATIENTS WHO ARE CONCURRENTLY RECEIVING OTHER NARCOTIC ANALGESICS, GENERAL ANESTHETICS, PHENOTHIAZINES, OTHER TRANQUILIZERS (SEE DOSAGE AND ADMINISTRATION), SEDATIVE-HYPNOTICS (INCLUDING BARBITURATES), TRICYCLIC ANTIDEPRESSANTS AND OTHER

CNS DEPRESSANTS (INCLUDING ALCOHOL), RESPIRATORY DEPRESSION, HYPOTENSION, AND PROFOUND SEDATION OR COMA MAY RESULT.

Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of meperidine and its capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. In such patients, meperidine must be used with extreme caution and only if its use is deemed essential.

Intravenous Use. If necessary, meperidine may be given intravenously, but the injection should be given very slowly, preferably in the form of a diluted solution. Rapid intravenous injection of narcotic analgesics, including meperidine, increases the incidence of adverse reactions; severe respiratory depression, apnea, hypotension, peripheral circulatory collapse, and cardiac arrest have occurred. Meperidine should not be administered intravenously unless a narcotic antagonist and the facilities for assisted or controlled respiration are immediately available. When meperidine is given parenterally, especially intravenously, the patient should be lying down.

Asthma and Other Respiratory Conditions. Meperidine should be used with extreme caution in patients having an acute asthmatic attack, patients with chronic obstructive pulmonary disease or cor pulmonale, patients having a substantially decreased respiratory reserve, and patients with preexisting respiratory depression, hypoxia, or hypercapnia. In such patients, even usual therapeutic doses of narcotics may decrease respiratory drive while simultaneously increasing airway resistance to the point of apnea.

Hypotensive Effect. The administration of meperidine may result in severe hypotension in the postoperative patient or any individual whose ability to maintain blood pressure has been compromised by a depleted blood volume or the administration of drugs such as the phenothiazines or certain anesthetics.

Usage in Ambulatory Patients. Meperidine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient should be cautioned accordingly.

Meperidine, like other narcotics, may produce orthostatic hypotension in ambulatory patients.

Usage in Pregnancy and Lactation. Meperidine should not be used in pregnant women prior to the labor period, unless in the judgment of the physician the potential benefits outweigh the possible hazards, because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development.

When used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce depression of respiration and psychophysiological functions in the newborn. Resuscitation may be required (see section on OVERDOSAGE).

Meperidine appears in the milk of nursing mothers receiving the drug.

PRECAUTIONS

As with all intramuscular preparations DEMEROL intramuscular injection should be injected well within the body of a large muscle.

Supraventricular Tachycardias. Meperidine should be used with caution in patients with atrial flutter and other supraventricular tachycardias because of a possible vagolytic action which may produce a significant increase in the ventricular response rate.

Convulsions. Meperidine may aggravate preexisting convulsions in patients with convulsive disorders. If dosage is escalated substantially above recommended levels because of tolerance development, convulsions may occur in individuals without a history of convulsive disorders.

Acute Abdominal Conditions. The administration of meperidine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients. Meperidine should be given with caution and the initial dose should be reduced in certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS

The major hazards of meperidine, as with other narcotic analgesics, are respiratory depression and, to a lesser degree, circulatory depression; respiratory arrest, shock, and cardiac arrest have occurred.

The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea, vomiting, and sweating. These effects seem to be more prominent in ambulatory patients and in those who are not experiencing severe pain. In such individuals, lower doses are advisable. Some adverse reactions in ambulatory patients may be alleviated if the patient lies down.

Other adverse reactions include:

Nervous System. Euphoria, dysphoria, weakness, headache, agitation, tremor, uncoordinated muscle movements, severe convulsions, transient hallucinations and disorientation, visual disturbances. Inadvertent injection about a nerve trunk may result in sensory-motor paralysis which is usually, though not always, transitory.

Gastrointestinal. Dry mouth, constipation, biliary tract spasm.

Cardiovascular. Flushing of the face, tachycardia, bradycardia, palpitation, hypotension (see Warnings), syncope, phlebitis following intravenous injection.

Genitourinary. Urinary retention.

Allergic. Pruritus, urticaria, other skin rashes, wheal and flare over the vein with intravenous injection.

Other. Pain at injection site, local tissue irritation and induration following subcutaneous injection, particularly when repeated, anti-diuretic effect.

DOSAGE AND ADMINISTRATION

For Relief of Pain

Dosage should be adjusted according to the severity of the pain and the response of the patient. While subcutaneous administration is suitable for occasional use, intramuscular administration is preferred when repeated doses are required. If intravenous administration is required, dosage should be decreased and the injection made

very slowly, preferably utilizing a diluted solution. Meperidine is less effective orally than on parenteral administration. The dose of DEMEROL should be proportionately reduced (usually by 25 to 50 percent) when administered concomitantly with phenothiazines and many other tranquilizers since they potentiate the action of DEMEROL.

Adults. The usual dosage is 50 mg to 150 mg intramuscularly, subcutaneously, or orally, every 3 or 4 hours as necessary.

Children. The usual dosage is 0.5 mg/lb to 0.8 mg/lb intramuscularly, subcutaneously, or orally up to the adult dose, every 3 or 4 hours as necessary.

Each dose of the syrup should be taken in one-half glass of water, since if taken undiluted, it may exert a slight topical anesthetic effect on mucous membranes.

For Preoperative Medication

Adults. The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously, 30 to 90 minutes before the beginning of anesthesia.

Children. The usual dosage is 0.5 mg/lb to 1 mg/lb intramuscularly or subcutaneously up to the adult dose, 30 to 90 minutes before the beginning of anesthesia.

For Support of Anesthesia

Repeated slow intravenous injections of fractional doses (eg, 10 mg/mL) or continuous intravenous infusion of a more dilute solution (eg, 1 mg/mL) should be used. The dose should be titrated to the needs of the patient and will depend on the premedication and type of anesthesia being employed, the characteristics of the particular patient, and the nature and duration of the operative procedure.

For Obstetrical Analgesia

The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously when pain becomes regular, and may be repeated at 1- to 3-hour intervals.

OVERDOSAGE

Symptoms. Serious overdosage with meperidine is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

Treatment. Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonist, naloxone hydrochloride, is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including meperidine. Therefore, an appropriate dose of this antagonist should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

In cases of overdosage with DEMEROL tablets, the stomach should be evacuated by emesis or gastric lavage.

NOTE. In an individual physically dependent on narcotics, the administration of the usual dose of a narcotic antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of narcotic antagonists in such individuals should be avoided if possible. If a narcotic antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care and only one-fifth to one-tenth the usual initial dose administered.

HOW SUPPLIED

For Parenteral Use

Detecto-Seal®—Carpuject® Sterile Cartridge-Needle Unit—2.5 percent (25 mg per 1 mL) **NDC 0024-0324-02**, 5 percent (50 mg per 1 mL) **NDC 0024-0325-02**, 7.5 percent (75 mg per 1 mL) **NDC 0024-0326-02**, and 10 percent (100 mg per 1 mL) **NDC 0024-0328-02** all in boxes of 10.

Each cartridge is only partially filled based upon product volume to permit mixture with other sterile materials in accordance with the best judgment of the physician.

Uni-Amp®—5 percent solution; ampuls of 0.5 mL (25 mg) **NDC 0024-0361-04**, 1 mL (50 mg) **NDC 0024-0362-04**, 1½ mL (75 mg) **NDC 0024-0363-04**, and 2 mL (100 mg) **NDC 0024-0364-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0365-04** in boxes of 25.

Uni-Nest™—5 percent solution; ampuls of 0.5 mL (25 mg) **NDC 0024-0371-04**, 1 mL (50 mg) **NDC 0024-0372-04**, 1½ mL (75 mg) **NDC 0024-0373-04**, and 2 mL (100 mg) **NDC 0024-0374-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0375-04** in boxes of 25.

Vials—5 percent multiple-dose vials of 30 mL **NDC 0024-0329-01**, and 10 percent multiple-dose vials of 20 mL **NDC 0024-0331-01** all in boxes of 1.

Note. The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid. Multiple-dose vials contain metacresol 0.1 percent as preservative. No preservatives are added to the ampuls or CARPUJECT Sterile Cartridge-Needle Unit.

For Oral Use

Tablets of 50 mg, bottles of 100 (NDC 0024-0335-04) and 500 (NDC 0024-0335-06); Hospital Blister Pak of 25 (NDC 0024-0335-02); 100 mg, bottles of 100 (NDC 0024-0337-04) and 500 (NDC 0024-0337-06); Hospital Blister Pak of 25 (NDC 0024-0337-02).

Syrup, nonalcoholic, banana-flavored 50 mg per 5 mL teaspoon, bottles of 16 fl oz (NDC 0024-0332-06).

Revised May 1988

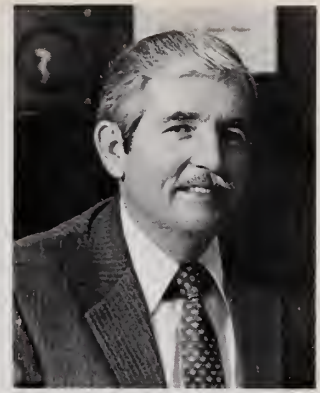
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EXECUTIVE DIRECTOR



S. Lon Conner
Executive Director, MASA

Voyage into Uncharted Seas

For some years now, the MASA staff in Montgomery has quietly assisted a number of physicians in resolving their differences with third-party payers, including the Blues and Medicare-Medicaid.

In the late summer of 1985, for example, MASA General Counsel Wendell Morgan and I saved Alabama physicians some \$600,000 in recoupment of Medicaid fees for a single quarter.

Earlier that year, the Medicaid Agency and HCFA attempted to recover physicians' payments for services in the last quarter of 1983 when the hospital had failed to file for the stays for which the physicians had billed.

The Alabama Medicaid Agency, interpreting rules promulgated in May 1983 limiting eligible hospital days to 12, had taken the position that physician payment for inpatient services was contingent on payment of the hospital claim. But many Alabama hospitals, incredibly, had failed to file claims for the period, forfeiting millions of dollars in Medicaid payments they might have received.

That default, Medicaid said, invalidated physicians' claims because, in the bureaucratic mind, they could not have provided services for stays that didn't legally exist.

In an editorial in *The Alabama MD*, I charged: "It is simply absurd for a physician's reimbursement to be contingent on the actions of others, over whom he has no control." I called such nonsense "Medicaid Roulette."

In the end, although it was like extracting blood from a turnip, this view prevailed, with Medicaid and

HCFA concurring. Had they not concurred, it is easy to see that projecting this single-quarter total of more than \$900,000 in physician charges to the years ahead would have meant the loss of millions of dollars in Medicaid payments for hospital visits. This intolerable situation would have hurt Medicaid patients more than physicians, since few doctors would have been eager to play this ridiculous game of chance. It had added insult to financial injury.

There have been scores of other examples of quiet, low-profile Association achievement over the past years. We have won some and lost some. But as the purse strings continue to tighten, the number of grievances by Alabama doctors has exploded. The regulations are more complicated with each passing week, and the federal government, as well as commercial payers, are under increasing pressure from their clients, whether taxpayers or industrial customers, to squeeze all costs to the peril point and beyond.

A great portion of physician anger derives from historic forces that are not amenable to remedy — health care costs are still rising at a dizzy rate that has business, industry and government cast in the role of hot-eyed penny-pinchers. So great is the problem from the payers' standpoint that calls for some form of national health insurance have taken on a wider and deeper dimension — the result of frustration over failure to check the health care inflationary spiral.

Carriers are subjecting every claim to NMR scrutiny. Computer surveillance of all physicians is now the norm of commercial and government payers, of

managed care systems and the self-insured. Gone, perhaps forever, are the days when physicians could expect virtually automatic reimbursement for their claims (even when poorly documented by contemporary standards). Now, as you know, virtually everything is challenged.

It is against this background that the Association is taking tentative, cautious steps toward formalizing what it has already been doing on a catch-as-catch-can basis: serving as the physician's advocate when there are real, glaring and legitimate policy questions at issue.

The Association cannot, of course, assume the considerable burdens of the claims departments of 5,000 doctor offices. Physicians must hire and maintain truly qualified claims people, see that they remain current, that they attend our seminars and workshops, and that they stay always tuned to the blizzard of changes.

What we are announcing is a program of selectively considering disputes that are widespread enough to have general applications in areas of fundamental importance to private practice, concentrating on those issues that go to the heart of the physician-patient relationship and the doctor's own essential role of advocacy — patient advocacy.

Legally and practically, MASA cannot enter the forbidden city of fee negotiation or the routine questions of adequacy of payment, except where this is a component of overriding policy questions. Doctors must themselves decide on adequacy of fee schedules, etc.

We will move very slowly at first; this is a Persian Gulf of mines; there are no maps of safe passage. We will entertain only those physician complaints that are presented fully documented and in writing, after the physician's claims personnel have exhausted their appeals for redress of the grievance, and then only when the physician has a legitimate and important case.

Just being mad at a carrier for receiving short shrift and/or inscrutable denials will not, usually, be grounds for MASA intervention. Anger is almost universal these days, but it alone won't win an argument with third parties.

There is no light that I can see at the end of this tunnel. Practice guidelines are on the way; DRGs for physicians may well be; all manner of assaults on traditional practice freedom are expected to multiply geometrically.

Obviously, if MASA is to be an effective advocate for the physicians, it must pick its campaigns prudently, not alone to efficiently utilize very thin personnel and financial resources, but also to maintain

credibility with those on the other side of the bargaining table. If we importune them with every little claim dispute, we would quickly jeopardize all standing for a fair hearing on the important questions. Also, petty wrangling would trivialize the Association's mission and image.

There are, I know, a few physicians out there who would like to see the Association in just that business — handling *every* claim problem. But unless the Association is to have a Pentagon-size staff, at comparable costs to the membership, I can't see that happening.

I am being deliberately general about the description of this undertaking for the reason that I have no clear vision of what lies ahead. We will be groping for a role, feeling our way as we go, ever mindful that those mine fields can be hazardous to the health.

It may well be that this endeavor will, over the next few years, grow into a substantial portion of the Association's work. But for now we are hoisting just a few sails as we embark on uncharted seas. Our navigation will be what old mariners called "dead reckoning." We'll point the ship on a best-guess heading and then check the stars along the way to see where we've been and try to establish the course changes needed.

To physicians with compelling grievances, we'll try to help, but again everything must be put in writing with full documentation for use by whatever level of expertise may seem indicated. As emotionally satisfying as it might be to a few physicians, we are not planning any glorious Kamikaze missions. Gradualism will be the watchword, at least until we get out sea legs.

I believe we can make a significant contribution; we already have been doing that in quiet, unpublicized cases over the years. And I know we will give it our best shot because the Board of Censors was unanimous in that directive, following the recommendation of the College of Counsellors and House of Delegates last April. □

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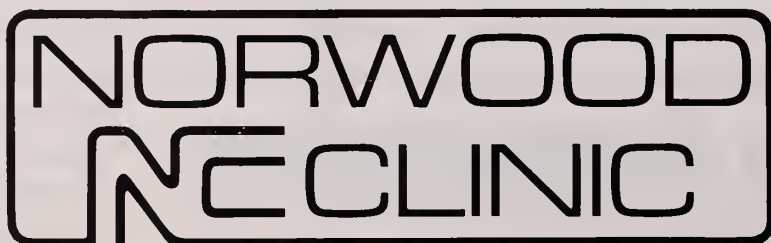
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Burt Taylor, M.D.
President, MASA

Where The Buck Stops

Most physicians understand all too well the meaning behind the vivid phrase of the late Senator Richard Russell of Georgia — “hell-hacked and harassed.” Bombarded by all the events of recent years, we tend to hunker down in our private foxholes and hope for deliverance with a new dawn.

But dawns come and go, while the shot and shell intensify. It is hardly surprising that in such straitened circumstances we develop tunnel-vision, seeing only that affecting us as individuals. If that means short shrift for our county and state societies and the AMA, so be it, many say with a shrug compounded of equal parts of resignation and a dangerous new philosophy of despair and cynicism.

With such a mind-set, we are often blind to problems in other sectors of the health care community. In my July column in this space, I mentioned how this state has a problem keeping some of the best and the brightest nurses. After the state of Alabama spends significant sums on their training, too many of them leave for greener pastures in other states.

Since there is a severe and growing national shortage, they have little problem relocating. The net effect of it is that Alabama, a relatively poor state, is subsidizing in some degree the supply of nurses in shortage states. (For too many years, incidentally, we also did that in public education — training teachers for better paying jobs in other states.)

This month I would call your attention to another sector that is in deepening trouble — the hospital industry. *New York Times* Business Editor Milt Freudenheim recently reported that health-care analysts on

Wall Street and elsewhere are saying the long-predicted shake-out in the \$200 billion hospital industry is gathering momentum.

Changes in the practice and financing of medicine have, as we all know, diverted many patients from general hospitals to specialized centers for outpatient surgery, cancer therapy, diagnostic testing, etc.

Already, according to the American Hospital Association, at least 43,000 beds have been eliminated since 1985. Under pressure from federal, state and private insurers, general hospitals made no money last year, AHA said; some 80 have closed or shifted to other care modalities. New York, where trends can be seen sooner and on a larger scale, hospitals suffered combined operating losses of more than \$1 billion in 1988.

Jeff Goldsmith, a health-care adviser to Ernst & Whinney, is perhaps overstating the case when he says: “The general acute-care community hospital is a goner. The acute-care market is dissolving.”

But he has studied all the numbers that we have not. In 1983, according to market experts writing in *Health Affairs Quarterly*, two-thirds of the Medicare physician dollar was spent in the hospital. Three years later, in 1986, that had dropped to less than half, and the trend-line is still down.

The sometimes frenetic advertising by hospitals, a comparatively recent development, has not been beneficial to the industry overall; some experts in the field say it has been a net loss, failing to produce enough new revenue even to break even with the added costs. But hospitals feel they have little choice to meet the

competition. The real winners, it appears, may be advertising agencies, television, and newspapers.

The Nashville-based hospital chain, Hospital Corporation of America, has sold off some of its less efficient hospitals and converted others to outpatient centers to compete with new trends. Thomas F. Frist, Jr., M.D., HCA chairman and chief executive, told *The Times* that the chain's university-connected hospitals are themselves threatened by the walk-in centers and are moving to protect themselves by emphasizing advanced services, such as kidney and pancreas transplants. Dr. Frist is blunt about such strategies: "We learned in the last five years that the more complex tertiary-care hospitals are the ones where occupancy is staying up."

But even at the large teaching hospitals, according to the Executive Director of the Federation of American Hospitals, "the trend lines are heading south." He is advising hospitals with credit wherewithal to borrow heavily and invest in capital-intensive high-tech units to draw doctors and patients away from weaker competitors.

But it is easy to see the distortions this may produce: while perhaps wise strategy for the larger and more powerful hospitals, such moves would accelerate the demise of smaller hospitals. The strategy also tends to favor big-city hospitals over community hospitals within the catchment. You don't have to be a certified economist to see that in a constricting market a net gain in one segment inevitably produces a net loss in another.

That has already happened, as we all know, with many community hospitals forced to organize long-term care in patients, homes and special centers for chronic ailments. Either that or they go belly-up. Already, according to Wall Street, one third of the 5,500 hospitals are offering "hospital-based home care" to survive in the chaotic market; but they are facing stiff competition from entrenched businesses specializing in home care, particularly in high-tech services, where the profits are.

One analyst said this trend to high-tech home care has already had an adverse effect on patient care: "We are probably overpaying as a society for the delivery of technology and underpaying, or not paying, for human services." Old people, he said, may get the finest in high-tech medical services but since they can't shop or cook for themselves they "end up starving and in an acute-care hospital."

The pressures of the new medical economics are distorting a system that evolved logically and in a fairly orderly fashion over the years. Just a few years ago, hospital administrators could devote most of their energies to improving patient care. Now, under the duress of galloping commercialization, their first duty is perceived to be survival in a dog-eat-dog market. This has, inevitably, devalued old priorities. All those in a position to pass the buck do so. But, the buck stops at the patient's bedside.

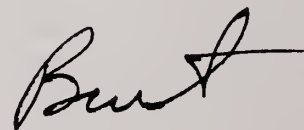
Most physicians are not phobic about change; we have traditionally welcomed progress in our discipline. But what bothers us most is that all these cost-cutting pressures, working their way through the system, tend to victimize weaker elements, which may not always be the least efficient, although that is the rationale of the cost-cutters.

"Whatever happens," says a health care analyst at Prudential-Bache, "you've got to be a low-cost producer." And that dictum defines what worries me most: For all of my practice lifetime, until recently, the engine that drove American health care to the pinnacles of world renown was the striving for excellence. If the new motivation toward low costs as the prime objective is allowed to dominate, the end-point is predictable: radically reduced quality of care.

In the catbird seat now are too many sharp-eyed management types spreading the pernicious doctrine that cheaper is always better. Americans, unlike any other people on the face of the earth, have long rejected that. Had this been the guiding principle a generation ago, I prefer not to contemplate where U.S. health care would be now.

If this philosophy dominates for the coming decade, I prefer not to think where our vaunted health care system will be at the turn of the century.

Hospitals have many problems and a plethora of new headaches. So do physicians. But neither can, in good conscience, ever forget the reason for their existence, patient care. □



**ROSALYN P. STERLING-SCOTT, M.D.**

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Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

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EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclo[®] in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclo[®] should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclo[®] penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclo[®]. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Claude L. Brown, M.D.

House Calls

It is generally the case that house calls are made infrequently. Paramedics make most such visits, and maybe this is just as well. But think: if a doctor made five house calls in one half of a day and by doing so was able to obviate hospitalization in just one of these patients — would not this be a “cost effective” procedure?

I am really just thinking aloud, of course. I am no economist and no strong advocate of house calls, but at one time they served many purposes, mostly constructive, and I just wonder . . . ?

I began making house calls at an early age; as a child, really, with my father who was not a doctor, but a druggist (they were “druggists,” rarely “pharmacists” then). Dad did not make diagnostic calls, but rather therapeutic ones. He would, on special occasions, deliver prescriptions himself — if he thought the patient needed special instructions that needed to be conveyed vis-a-vis, or perhaps for reasons known only to himself.

We entered a variety of homes; there were no wealthy families in our area — some middle class and many poor. I noted that Dad was always treated with respect, often affection, and the medicine he dispensed was regarded as if it were holy water. He was universally called “Doc,” and I, “little Doc.” Such obvious fawning of one’s narcissism is not to be ignored. These experiences have to be part of the reason for my choosing a medical career.

Immediately adjoining the drugstore were the offices of two doctors, and across the street was another. One of the doctors proclaimed that he could practice medicine with only six drugs; I overheard my father tell the other druggist that this statement was no idle boast but a fact, and that the doctor commonly used only four.

These doctors apparently worked all the time: a house call might take several hours, and upon returning to the office he would find it full of patients. The phone rang often at night; he would be tired the next morning, and another day would be repeated as the former. Sunday was the only time that this process changed.

I was close to one of these men and he took me on many house calls. My main function on these journeys was to keep him awake by talking. I have no idea what we talked about — the content was not important; it was sound that counted. When I was 15 he began to have me chauffeur him on long house calls. He would get in the back seat and doze, staying awake only enough to direct me to the patient’s house, or to urge, “Go a little faster now — the road is not that bad.”

However, the road always *was* that bad. Where we went, there were no paved roads, none at all. Even the main road on which the stores and offices were located was hard dirt and gravel. Off the road, things deteriorated quickly.

One Saturday afternoon Dr. Snowden stuck his head in the door of the store and called to me, “Let’s take a long ride.” It was a raw March day; there was no temperature control in cars then — they were cold in the winter, frizzling in the summer.

He relaxed on the back seat with his overcoat thrown over his legs and gave me directions. Beneath a gray sky, dust blew from the field and the road. In 20 minutes we arrived at the last turn-off described by him, and the road, already poor, turned into a two rut wagon trail.

“Is this it?” I asked.

He looked out the window and quickly laid back saying, “Okay, you don’t have to slow down much.”

We slammed into several pot holes, ricocheted from one hummock to another, and then the trail began to

twist between large pine trees. Unable to rest with the car changing course so abruptly, Dr. Snowden struggled upright.

"We've got just about a half-mile more" he said. "The midwife called in from the nearest phone and told me this woman had a hard labor and might start hemorrhaging."

When we reached the crest of a gentle hill, I saw a small valley, mostly cleared for cultivation, with the trail curving down, then up, past two small unpainted houses. In a field close by a black man plowed a strapping gray mule. Dr. Snowden said, "Stop and let me ask him which house."

In response to my shout the man took the reins from around his neck, tied them to a plow handle, and walked to the car. Spying the doctor's face in the window he immediately said, "You're Dr. Snowden — I know you, you tended to my boy one time, he cut his foot and you sewed him up. I guess you're looking for Ms. Arthur — she stay in that second house." He took off his cap and wiped his brow with his sleeve.

Dr. Snowden thanked him and we drove to the designated house. There was a swept yard with chickens pecking and scratching, wooden steps to the front porch ("Don't trust wooden steps; half of them in these houses are rotten," the doctor had told me), two chinaberry trees near the porch and a fig tree by the rear corner.

An old woman let us in. The fireplace made the room comfortable; I stood watching the fire while Dr. Snowden examined Ms. Arthur in the bed. He talked to her and to the old woman, her mother. A young girl brought in the baby, securely wrapped, for the doctor's inspection. He was satisfied with the baby, and with the condition of Ms. Arthur.

"You're going to be fine," he told her with a smile. "I'm leaving you some medicine. If you need me, you have somebody run to that phone over the hill and call me."

He stripped off his rubber gloves, put his coat on and we said good-by to the Arthur's. Dr. Snowden was in a good mood; he half sang a rather tuneless ditty:

*"The blue bird whistled and the jay bird danced,
And the old cow died in the fork of the branch —
Oh, I don't want to go home."*

I spun the "knee action" Chevrolet around. I doubted that the knees would ever be the same after this ride,

but it was his car and his urging me on to greater speed. We eased up the hill in second gear. The man was still plowing. I could see that the pleasant mood was lasting because Dr. Snowden said, "Wait a minute," when the plow-man, coming to the end of the furrow close to us, paused and waved. The doctor didn't often waste time.

"How Ms. Arthur?" asked the man.

"She's fine — everybody is all right. That is a handsome mule you have there."

"Yes sir, thank you, sir. She's smarter than a woman and a lot easier to manage." He grinned proudly.

When we were back on the highway, I glanced in the rear-view mirror; Dr. Snowden was sleeping, mouth open slightly, features relaxed, at ease in Zion.

I made many house calls when an intern, for we were riding ambulances then. The functions of these calls were either to provide transportation to the hospital for the patient; occasionally to pronounce someone dead; or to give strictly emergency treatment at some disaster. We did not bring a well-rounded medical approach to any crisis.

In the first 10 years or so of psychiatric practice, I frequently made house calls at the request of referring physicians. Most of these visits were unnecessary in terms of the patient's inability to get to the office due to physical infirmity or lack of transportation.

These usually were dependent people, accustomed to manipulating others into satisfying their neurotic wishes. A few were truly house-bound, but the majority just wanted the doctor to talk with them in their own homes — a perfectly understandable wish, impractical as a steady program.

One generality above all: a house call puts a powerful dimension into the doctor-patient relationship. Neither the patient (I have been one), nor the doctor (I am one) — will ever forget the home visit. Both parties see important pieces of each other that are not otherwise visible.

Like most therapy, the specific words may well be forgotten, but the presence is etched forever.

I wonder how many doctors have been sued who have made a house call on that patient? □





CALL FOR PAPERS

Medical Association of the State of Alabama SIXTH INVITATIONAL SCIENTIFIC SYMPOSIUM

Saturday, January 20, 1990 — 9 a.m. to 4 p.m.
The Edna Merle Carraway Convention Center —
Birmingham

Purpose of the Program — This program is designed to allow Alabama physicians to share with their colleagues current research efforts and professional concerns. Topics selected will cover a wide range of medical interests.

Program Format — The program will be structured from the papers submitted by Alabama physicians. Time will be scheduled for questions. Registrants and participants will receive advance copy of all papers.

Paper Selection — Papers will be selected using the following criteria and procedures.

1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written materials to be used with the presentation for the study and use of the attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interest to offer a balanced program of general interest.

Symposium Timetable . . . August 15 to October 15, 1989 — Call for abstracts. October 15, 1989 — Final date for abstracts to be received. Late October, 1989 — Review of abstracts by the Council on Medical Education and final selection of papers. November-January 1990 — Announcements of selections; publicity and promotion of Symposium, printing of abstracts and handouts. January 20, 1990 — Program in Birmingham.

Symposium Topics — To acquaint potential presentors with the kinds of subjects that might be suitable, the speaker and topics at the 1989 Symposium are listed below.

Max Michael, M.D. — **Mohammed's Mountain-Delivery of Health Care to Homeless People**; Robert Pieroni, M.D. — **Digitalis Toxicity**; Ruby Meredith, M.D. — **Advances in Hyperthermia for Control of Cancer**; Steven Stokes, M.D. — **Intraluminal Irradiation for Obstructing Endobronchial Carcinoma of the Lung**; Cynthia Lorino, M.D. — **The "Abnormal" Breast; Biopsy Is Not Always Necessary**; Rudolph M. Navari, M.D. — **An Overview of Bone Marrow Transplantation**; Howard C. Snider, Jr., M.D. — **A Surgeon's Encounter with the Malpractice Crisis**; Robert L. Baldwin, M.D. — **Tinnitus-An Old Nemesis: Evaluation and Treatment of the Problem Case**; Richard W. Waguespack, M.D. — **Current Concepts in the Management of Sinus Disease**; John Gerwin, M.D., et al. — **Evaluating the Patient with Hoarseness — A Clinical Guide**; Paul S. Howard, M.D. — **Body Sculpting with Suction Assisted Lipectomy: Is It Safe and Does It Work?**; David Montiel, M.D. — **Outpatient Angiography: Two Year Retrospective Review**; Zenko Hrynkiw, M.D. — **Current Diagnosis and Treatment of Lumbar Disc Disease**.

Abstracts — Abstracts of the proposed paper (200-300) words, double-spaced) should be sent to the Council on Medical Education, using the form below, or a similar format.

ABSTRACT

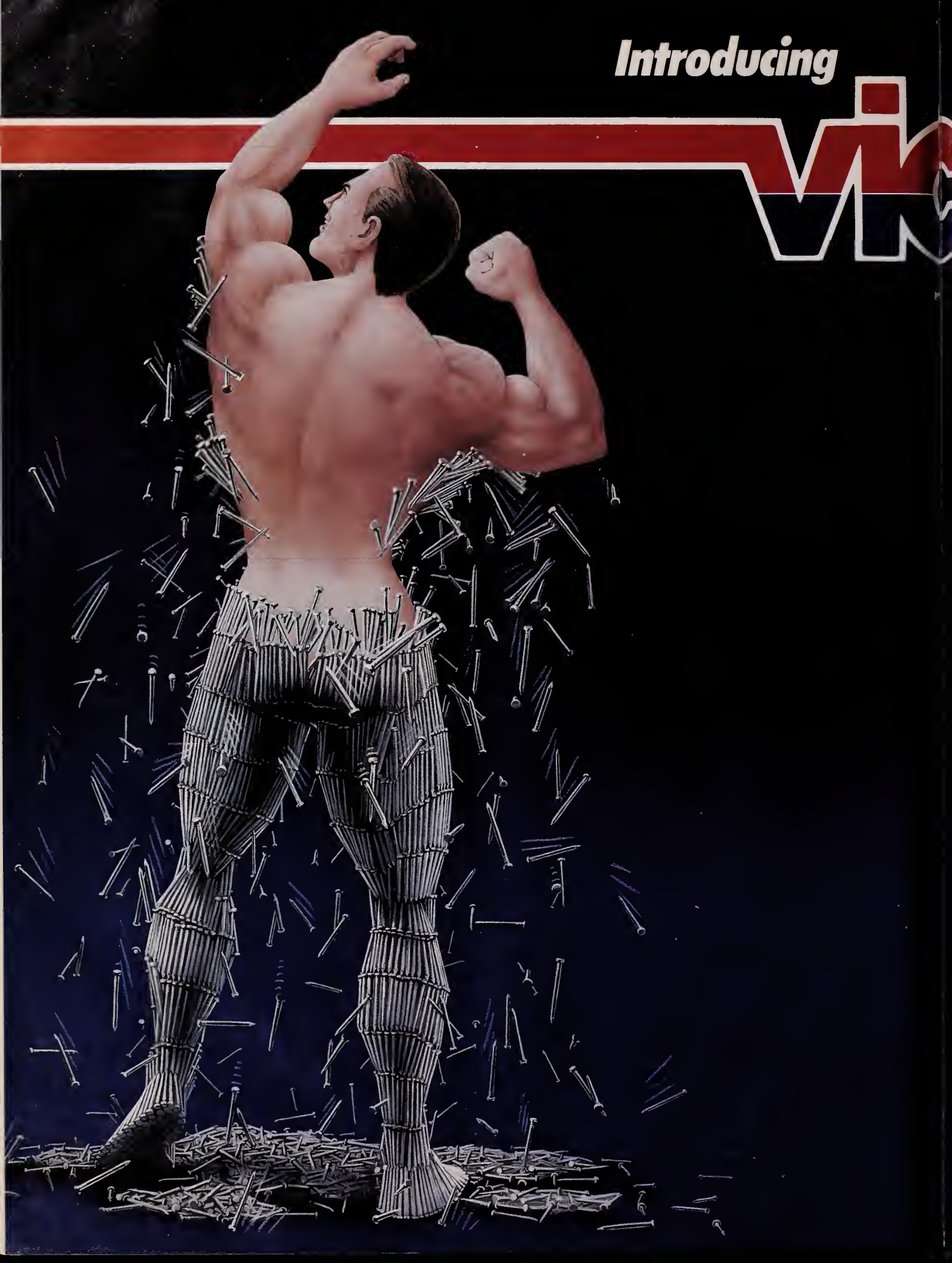
TO: Council on Medical Education, MASA, P.O. Box 1900, Montgomery, AL 36102

I would like to present a paper at the MASA Invitational Symposium on Saturday, January 20, 1990 at the Carraway Convention Center in Birmingham. An abstract (200-300 words doubled-spaced) is attached.

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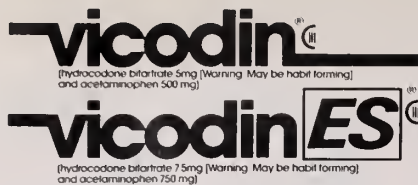
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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

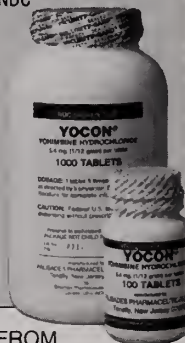
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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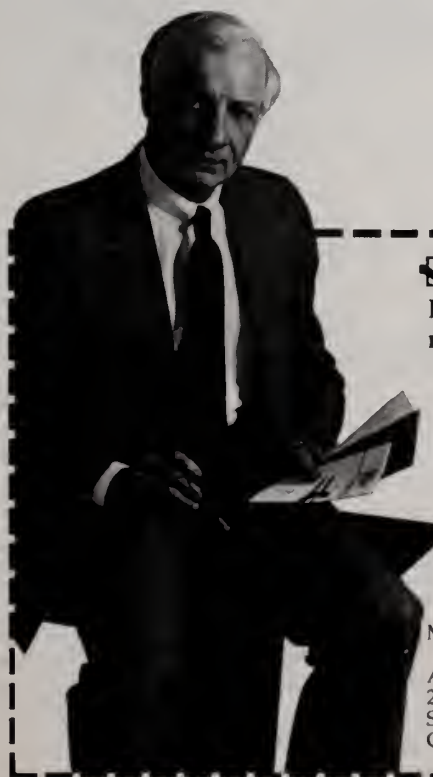
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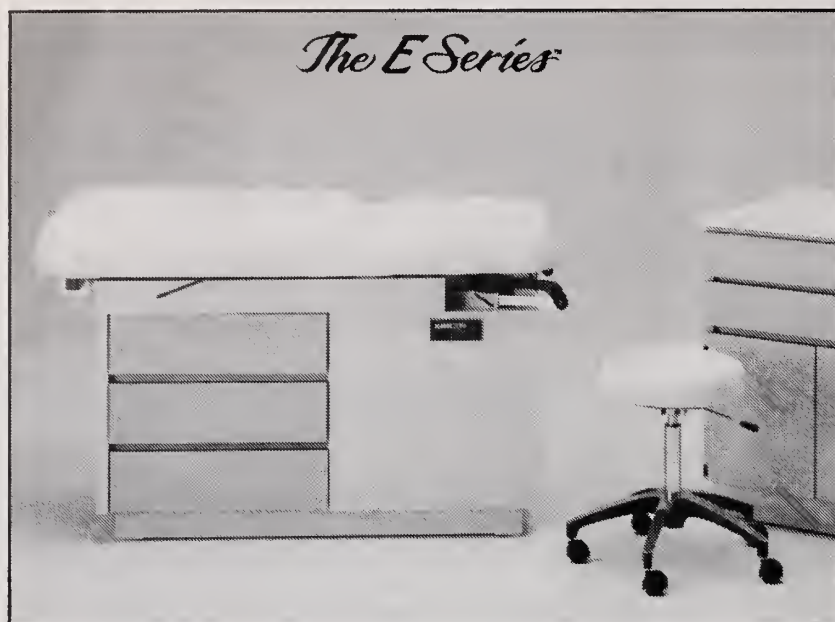


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A-MASA President*

Our Belle

Belle Chenault (Mrs. John M.), our Belle of Decatur, Alabama, was AMPAC Liason of the American Medical Association Auxiliary for 10 years, serving for part of that period as Secretary-Treasurer of the AMPAC Board. In 1987, the "Belle Chenault Award for Political Participation" was established by AMPAC and named in Belle's honor. It is to be awarded every two years to an auxiliary member who has done outstanding work in the field of political action. It is an unique honor to have an award named for one; we know of no other AMPAC or AMA award named for an Auxiliary member!

Belle has served the national auxiliary as president, president-elect, first vice president, historian, director, and bylaws chairman. Other national positions she has held include rural health chairman, membership chairman, Today's Health chairman, program chairman, and member of the finance, nominating, structure review and health manpower committees. These positions spanned the period from 1955 through 1971. She has been an auxiliary member since 1946 and has served both her state and county auxiliaries in many capacities. She was president of the Auxiliary to the Medical Association of the State of Alabama in 1954-1955, and was twice president of Morgan-Lawrence County Auxiliary. She has been a member of the state auxiliary board since 1949 and was made an honorary member of the state auxiliary in 1966. She is presently serving on the President's Council of A-MASA. She is past president of the Southern Medical Association Auxiliary.

A graduate of the University of Alabama where her father was professor of organic chemistry, Belle Montgomery Chenault met her husband as a student at the University, and they were married in 1941. Dr. Chenault has been very active in the Medical Association of the State of Alabama, serving in many capacities including chairman of the Board of Censors, and retired in 1985 after practicing general and industrial medicine in Decatur, AL for 40 years. The Chenaults



Belle Chenault (Mrs. John M.) presents the "Belle Chenault Award for Political Participation," which was named in Belle's honor, to the 1989 winner Becky Smith of Florida.

have five children: Alice Chenault, M.D., Huntsville, AL; Belle Chenault Mortenson, Seattle, Washington; John Chenault, Jr., Seattle, Washington; Leigh Chenault Pedigo, Charlotte, North Carolina; and Martha Chenault Marks, Decatur, AL.

Always a dedicated worker in Decatur, Belle's special interests have included the Girl Scouts; Daughters of the American Revolution; the Garden Club of Alabama; Decatur Mothers Club; League of Women Voters; Women's Chamber of Commerce; American Association of University Women; PTA; and Decatur Mental Health Association. She has served as officer of many of these organizations. She has been a Red Cross water safety instructor. Presently she is First Vice President General of the National Society Colonial Dames XVII Century. She is a member of the Baptist church, Sunday school teacher of an adult women's class, and sings in the Sanctuary choir.

She also is a member of Phi Beta Kappa, Kappa Delta Pi, Alpha Lambda Delta and Mortar Board honoraries; Zeta Phi Eta professional speech sorority; and Kappa Delta social sorority of which she is past president of the Decatur Alumnae Association.

Such a busy lady! Yet she has time to listen to my Auxiliary plans and make helpful suggestions, to attend our state workshops and annual meetings, and to remain active in Morgan-Lawrence County Auxiliary. And I'm sure that she always works for the political candidate of her choice, and would encourage each of us to do the same.

Excerpts from Belle's speech when she presented the "Belle Chenault Award" for 1989 at the June 19 AMPAC Breakfast are as follows:

"It is a pleasure to be here this morning to present the award named in my honor. It should rightfully be called the Edie Epstein award, for it was her idea to make such a presentation biennially to an auxiliary member for outstanding political participation. That Edie and the AMPAC Board saw fit to name the award for me is one of the greatest honors of my life.

"It seems only fitting that this year's award should go to an auxiliary from Edie's own state, Florida. The 1989 recipient only recently entered the political arena, but she has really made her presence felt. Let me tell you the story.

"When Becky Smith was first approached about becoming involved in the state legislative race of Dr. Ben Graber, she didn't even know the candidate, and

she knew very little about political campaigns. However, she was the President of the Broward County, Florida, Medical Auxiliary and had a local reputation for excellence in organizational and volunteer skills.

"Dr. Graber heard Becky give a speech at an auxiliary dinner, and when he had a chance to talk with her personally, he knew she was the kind of campaign staffer he needed to help him defeat his opponent, an incumbent state representative — who was also a trial attorney.

"Becky began as just one worker among many, but she progressed rapidly to being press secretary and then campaign manager of the entire organization. She was involved in every facet of the campaign — fundraising; coordinating volunteers; putting together literature, press releases, and television appearances; running the campaign office and, finally, making decisions when the candidate could not be reached.

"Dr. Graber says: 'Becky Smith ran a campaign that professionals in the business viewed as one of the finest races seen in Broward County in the last 20 years.' Yes, Dr. Ben Graber won the election.

"Since November, Becky has been getting ready for the 1990 campaign. She has become one of the most influential and sought-after personalities in the Broward County Democratic Party. She has attended the AMPAC Campaign Management School and the Advanced Campaign School to further refine her political and organizational skills, with the cooperation of her children and her husband, who is an anesthesiologist. I think you will agree that Becky Smith not only deserves the Belle Chenault Award for Political Participation, but also our applause and our thanks for a job well done."

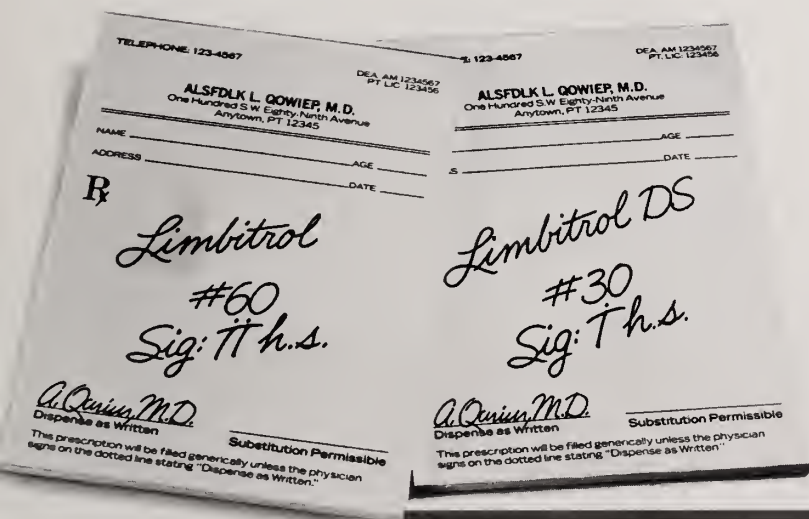
I think that YOU will agree that Belle Chenault not only deserves OUR applause, but our thanks for a job well done for our auxiliary.

We think it appropriate to start a Spousal Membership in ALAPAC and AMPAC to encourage Alabama Auxiliary members to become politically active in the party of their choice. Spouses should have received a letter announcing this membership. We hope they will be interested and that you will encourage them to respond. □

Martha Anne

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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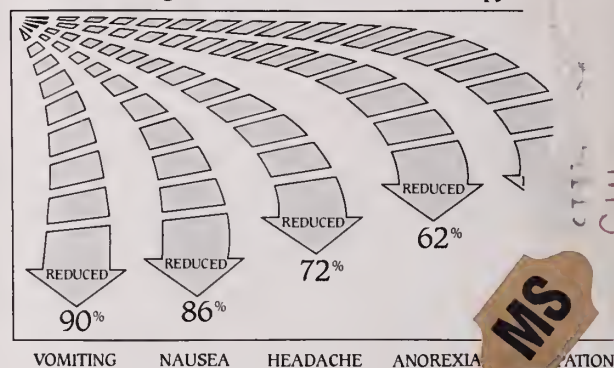
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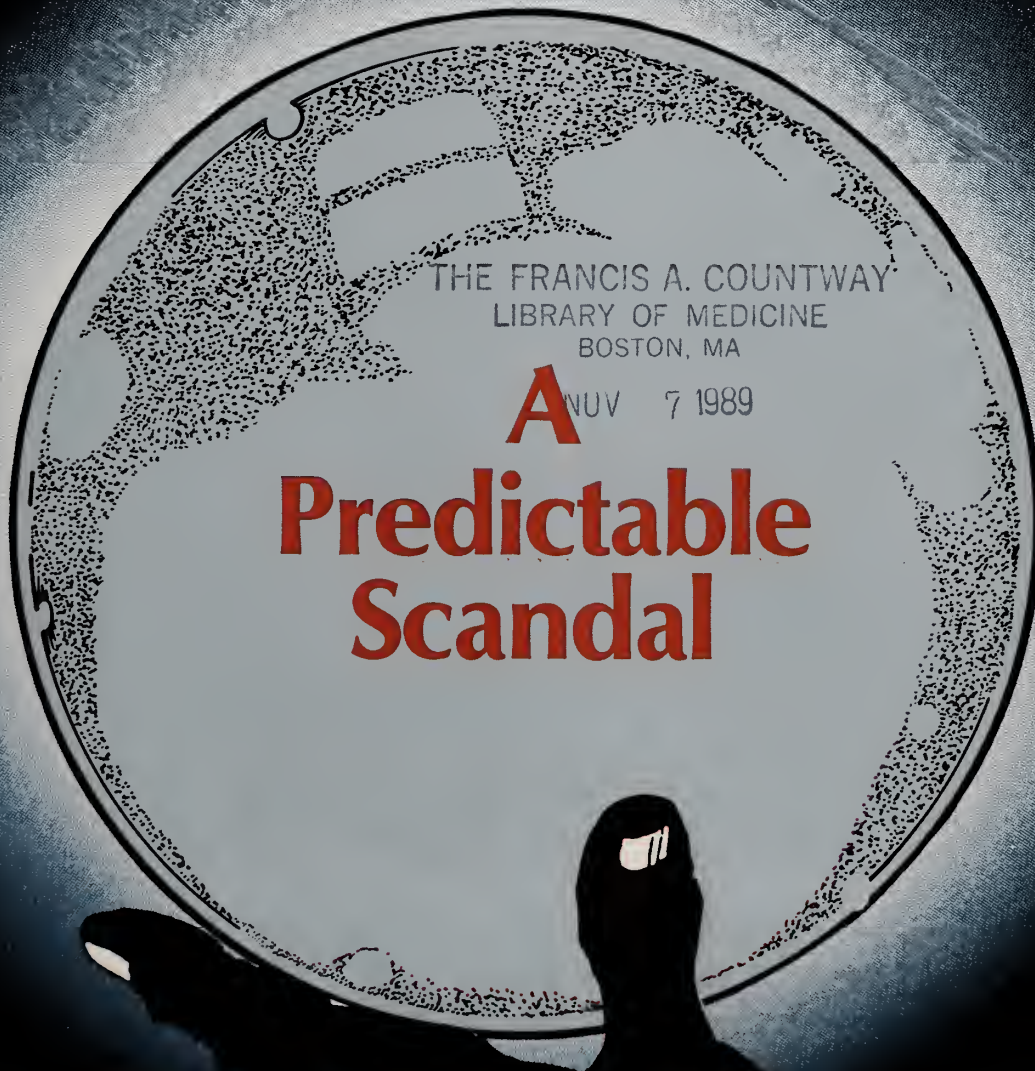
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Alabama Medicine

October 1989 Vol. 59, No. 4

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA



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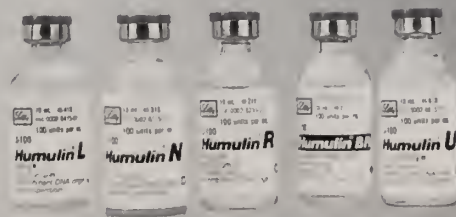
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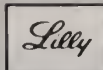
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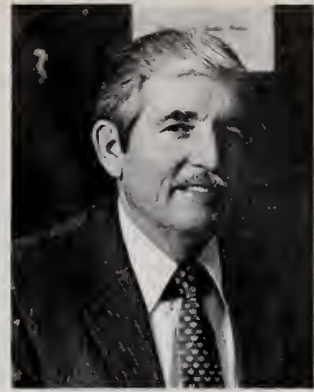
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Dole Fever

In mid-summer of 1988, at the time of passage of the catastrophic addendum to Medicare, it was confidently predicted by the computer whiz kids in the Congressional Budget Office (CBO) that the liberalized benefits for use of skilled nursing facilities (SNFs) would add about \$400 million per year to the Medicare bill.

In August of 1989, 13 months after that prediction, CBO confessed to a slight error in projection. The SNF cost increase would be about \$2.4 billion a year, or 500% more than the 1988 projection.

This is simply unbelievable. Worse, it casts into doubt virtually all federal projections and causes the average taxpayer to wonder if the federal government has any idea what it is doing. The forecasters have a vast arsenal of supercomputers at their disposal, but CBO could scarcely have been further off using an abacus, or by simply drawing a random number from a fishbowl. Maybe what is needed to apply NCAA's Proposition 48 to the job qualifications for Medicare forecasters, who ought to be at least as smart as interior linemen.

These forecasters make much of their claimed ability to factor in "behavioral offsets." Translated from Potomacese, that means what people will probably do in response to program changes. It applies to providers, the Potomac pundits say, as well as to beneficiaries. The forecasters claim, for example, to be able to predict with a high degree of confidence how physicians would react to a relative value system. They believe they know what those specialists whose services are devalued might do to stabilize their income; similarly, they believe they can predict with acceptable accuracy

what the response would be of physicians whose services are upgraded in value; what beneficiaries would do; and so on.

But look at the short history of the 1988 catastrophic plan and its accompanying economic predictions and you have reason to doubt this expertise. In the summer of 1988 all the forecasts said the surtax and the premium add-on would pay for the program. By late winter and early spring of this year, CBO forecasters said the program was accumulating a huge surplus.

In April of this year, Senator Lloyd Bentsen, Chairman of Senate Finance, was talking about cutting the surtax because it was producing far too much excess revenue. He had to abandon that in July when CBO ran another projection showing that drug costs would be far higher than originally predicted, adding \$5 billion to the cost of the program. Bentsen's surplus evaporated.

Within a month, CBO and HCFA were saying Medicare beneficiaries were using SNF at a rate six times the prediction of just a year before. In the space of a few months a huge surplus had turned into a monster deficit. Already the catastrophic add-on was headed for Chapter 11. So much for behavioral offset.

Now the same people who brought you this remarkable exhibition of economic soothsaying want you to believe that they really know their stuff when it comes to setting Expenditure Targets. As you know, ETs would be set from a variety of factors, and if costs ran over the target, physicians would be penalized in a subsequent year by the amount the target was missed. But physicians wouldn't establish the target: that would be done by the computer geniuses in Washington. If

they are wrong, which seems a lead-pipe cinch, physicians would be penalized for the goof.

There is no other way to describe that eventuality than what it is, an unjust and idiotic shifting of bureaucratic incompetency to physicians

AMA Senior Deputy Executive Vice President James S. Todd, M.D., noted the obvious parallel between the SNF disaster and the confidence the same forecasters have in setting ETs. Dr. Todd said, "The backing and filling we have seen in trying to cost out catastrophic leaves little confidence in the government's ability to predict with reasonable accuracy either the future costs of Medicare or an expenditure target." (*American Medical News*, Sept. 8.)

Ross Anthony, Ph.D., associate HCFA administrator for program development, said there were no such risk of lousy ET forecasting: "Physician fees are really quite different because we have a lot more data and information."

Taking him at his word, perhaps we can expect as high as a 50% improvement in ET forecasting compared with SNF. If so, HCFA and CBO would miss by only 250%, which is scarcely reassuring.

By the time this appears, the catastrophic provision will likely have been repealed or substantially amended. Senator Bentsen, for his part, is at least honest about the alternative to higher taxes — decreased benefits, he says. In short, more rationing, added to that rationing already imposed by various devices designed to camouflage the fact.

I have the greatest sympathy in one respect for the Administration, Congress and the federal bureaucracy. They are caught between powerful forces: the public's demand for more and more, always accompanied by that same public's insistence that there be *no new taxes*.

Congressmen returning from their August vacation reported that they were appalled by the public's want list and the cavalier public indifference to the deficit and the Alpine national debt, which continues to mount even as I write.

Many Congressmen said the public doesn't see the connection between entitlements and the depleted national treasury. Most people will brook no discussion of deficits, which they regard as diversionary tactics intended to deflect their demand for more of everything from Washington. They want to see the sky darkened with fleets of B-2 bombers, never mind that each plane literally cost more than its weight in gold; they want more highway money to facilitate their pleasure travels; they want federal day care for old and young alike; they want full government payment of nursing home care for the elderly; and, of course, they want more tax cuts.

Returning Congressmen were simply flabbergasted. But given this attitude out there, with just about everyone holding out his hand for a federal dole of some kind, can it be at all surprising that the first year of catastrophic was itself catastrophic? People will trample each other to claim anything they think is their due.

Just as surely, if ETs are imposed, costs overruns generated by such rising expectations and insatiable appetites for everything labeled free will wreck the forecasts. And you know who will get the blame for that — greedy doctors.

There are times when I throw up my hands and agree with Eric Sevareid's famous *bon mot* that the last federal program that worked was World War II. □

Lon

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*Burt Taylor, M.D.
President, MASA*

A Predictable Scandal

There is an inescapable object lesson in the current generic drug revelations. To review that scandal briefly:

Since June, The FDA had, at this writing, moved to revoke its approval for 30 generic drugs made by three companies; another 141 compounds were under severe "suspension." Companies accounting for some 18% of the generic market were under FDA investigation.

There have been widespread and alarming charges of corruption in the generic industry; reports of hush money and kickbacks to FDA inspectors; allegations of fraudulent submission of samples by manufacturers to the FDA for testing; and so on. It appears to be a major and squalid story of deception, double-dealing, duplicity and outright criminal conduct.

The implications for physicians and their patients are obviously broad and troublesome. Kaiser Permanente, the big Oakland, California, based HMO, had been using generic blood-pressure medicine, produced by Bolar Pharmaceutical. But when the FDA announced Bolar was under investigation, Kaiser pulled the generic and went back to SmithKline's Dyazide. The organization said it couldn't afford to take chances.

AARP, however, which dispenses 15 million Bolar blood pressure generics per year, said it was continuing to ship the product through its mail-order pharmacy for the time being. If the product is proven defective, AARP will have to answer to its membership.

But such details of the scandal and its consequences are less important, in the long term, than the forces that made the scandal virtually inevitable — the irrational pressure for cheaper health care at any cost.

At stake in the drug war is a \$25 billion retail and hospital drug market. The federal government, health

insurers, managed care overlords, and other technocrats seeking to control health costs have driven the market for generics at a frenetic and reckless pace that would virtually guarantee trouble. Although pharmaceutical companies have made generic forms of brand-name medicine for more than two decades, the industry was not a major factor until Congress passed the Waxman-Hatch act in 1985, expediting the approval process for the compounds.

Under the new law, rather than prove the safety and effectiveness of drugs in lengthy and expensive clinical trials, companies had only to show the FDA that their product is "bioequivalent" to the brand-name counterpart.

The message received by the industry, however, was clear: the cautious and deliberative process of scientific validation was being massively compromised in the interest of economy. This was Congress's Big Wink, clearly telegraphing the message that price was to be paramount over quality.

So two major elements combined to produce the present scandal: a rich and tantalizing market of \$25 billion; a new law that brazenly courted cheap production. Leaving aside the familiar contention that FDA's approval process has been unnecessarily slow, Waxman-Hatch appeared to advertise cheapness as the new priority.

It should hardly be surprising that the lure of quick riches, coupled with relaxed standards, begat short-cutting and degraded quality control.

The generic industry already had a good thing going for it, the free gift of important and lucrative drugs on which the patents had expired. The original developer of the drug paid for years of highly expensive R&D while the generic imitator pays for none of this. In

addition to the windfall of previous and current patent expirations, from 1991 to 1995 patents will expire, according to *The Wall Street Journal*, on drugs accounting for \$10 billion in annual sales. These include Tagament and Zantac.

Small wonder that the Japanese just recently bought one of the U.S. generic companies for a price reported to be close to \$1 billion — a company that had been sold just a few years ago for less than \$3 million.

It is this grossly distorted market that concerns me here, not the relative merits of brand-name and generics. It was this congressionally inspired gold rush fever that produced the scandals as surely as night follows day.

That same consortium of pressure groups, in both the public and private sectors, is just as determined to get bargain-basement medical care, hang the consequences. And just as surely this notion that cheaper is better will result in comparable degradations in health care for the nation's patients.

This kind of planned disaster has been going on as long as civilization itself. John Ruskin, the noted British writer and critic of the 19th Century, sadly noted that never in the history of man has there been an excellent product or service that someone has not been able to knock off with a shoddy substitute. In other words, true craftsmen and opportunistic mountebanks have been at war for the public's affections since the dawn of human history.

If you are foolish enough, you can buy a "genuine Rolex" watch, encrusted with diamonds, for \$20 or

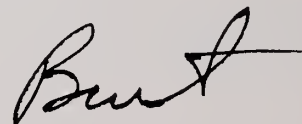
so on the sleazy streets of New York or any other major city. But closer inspection will reveal the copy is basest junk; the diamonds are glass; the innards are comparable to any other shoddy watch, with accuracy measured in hours rather than in fractions of a second.

Nowhere, however, is the high cost of cheapness more appalling than in medical care. The sucker who gives a con artist \$20 for a junk watch has lost just that much to his folly, and perhaps the lesson was worth it. In health care, however, the calculated sacrifice of quality for price doesn't occur on the mean streets but in posh offices where the price-cutters plot their "economies" sitting at powerful computer consoles. And the consequences in morbidity and mortality are infinitely more serious.

What has been accomplished in genuine cost containment, with no compromise in quality, has been done by physicians. What is being dictated by invisible MBAs, clerks and other market manipulators is a dangerous trend toward the enshrinement of hazardous corner-cutting and product-dilution as the new standard of market achievement.

As in the generic gold rush, the public is the potential victim of a movement that seems to fly battle flags reading, variously, "Cheaper is Better," and "Less is More," the very kind of perversion of truth George Orwell dubbed "doublethink" decades ago.

I hope the generic scandals raise warning signals to those who appear to have trouble distinguishing between trimming fat and slashing healthy bone and tissue. □



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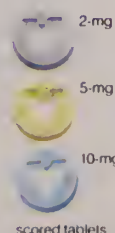
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Improving Diagnostic Accuracy in Appendicitis

John B. Blalock, Jr., M.D.*

Introduction

During this century, several hundred articles have been written about appendicitis and appendectomy. I don't suppose that in this article I will state much that hasn't been discussed many times in the literature. What I have done is to review my care of 123 patients who had a preoperative diagnosis of appendicitis and hold their management and final diagnoses up to the information in the literature. I will discuss what I have learned from the successes and errors in diagnosis, and I'll make some suggestions which may improve the accuracy of diagnosis of appendicitis.

All surgeons who care for patients with appendicitis are well aware of the real and sometimes severe morbidity coming from gangrene and perforations. In addition I would wager that most surgeons know of mortalities from appendicitis among patients cared for during their residency days or perhaps among the elderly patient population of their present practices. In the group of patients treated by Reginald Fitz of Boston in 1886, all of the patients had perforation and right lower quadrant abscess.¹ Probably, because of increased public and doctor awareness of the dangers of appendicitis, plus the use of antibiotics, the mortality rate from perforated appendicitis has decreased throughout the century. Table 1, taken from an article by Dr. John Berry, Jr. and Dr. Ronald A. Malt, shows this decrease in mortality.¹ The 254 patients listed were randomly selected, but most series from the last three decades report a consistent mortality of four to six percent in cases of perforated appendicitis.²

Balanced against these penalties paid for "missing" or "waiting too long" in case of appendicitis, surgeons have the responsibility to not operate unnecessarily and thereby cause pain, a small incidence of infection, and lost time from school or work generated by a "negative appendectomy."

It is well documented that there is a "linear correlation between the rate of perforations and the diagnostic accuracy."¹ Again from Dr. Berry and Dr. Malt's article, Graph 1 represents the rate of perforation in 13,848 patients with proven appendicitis.¹ Each point represents one series. The series which had the best diagnostic accuracy (89%) also had the highest perforation rate (29%). Conversely, the lowest accuracy rate (67%) was associated with the lowest rate of perforation (14%). The general consensus is that a certain percentage of normal appendices should be removed to avoid perforations. This number is probably ideally in the neighborhood of 25%.

Patient Information

Patients with Appendicitis

From early July 1980 through June of 1988, I operated upon 123 patients for abdominal complaints presumed to be due to appendicitis. Of the 123 patients, 81 had appendicitis, or specifically, inflammation of the appendix itself (versus "periappendicitis"). Table 2 shows the age and sex distribution among the 81 patients.

As Table 3 shows, not all of the 81 patients with appendicitis responded to the questions regarding their symptoms. Of those who responded, the percentage incidence of these symptoms is listed and is what one would expect.

Table 4 shows the physical findings of these 81 patients — again not surprising.

In 74 (91%) of the 81 patients, the WBC was greater than 10,000. In 19 of 75 urinalyses (25%), ketones

TABLE 1

Mortality Rate from Appendicitis

	All Cases of Appendicitis Studied		Appendicitis with Perforation	
	N	%	N	%
1929-1939	3301	3.1	671	13.0
1937-1959	5832	1.2	1057	5.9
1974-1978	254	0.8	70	0.0

* St. Vincent's POB I, Suite 620, 2660 10th Ave. South, Birmingham, AL 35205.

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TABLE 2

Patients with Appendicitis
(N = 81)

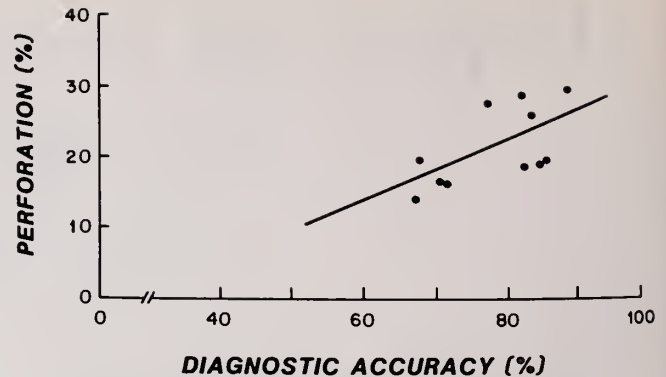
Diagnostic Accuracy of 66%

Age range	7 years to 83 years
Males N=44 (54.3%)	avg. age 28 years
Females N= 37 (45.7%)	avg. age 34 years

were present. Abdominal films were rarely obtained in this group of 81 patients. Three patients had fecaliths seen by the radiologist. Barium studies are sometimes helpful in diagnosing appendicitis especially when there is extrinsic compression on the cecum seen when there is non-filling of the appendix. These findings were noted six hours after a barium swallow (Figs. 1A and 1B) in a seven-year-old girl who had a coincidental urinary tract infection along with her perforated appendix. A 68-year-old female also demonstrated these findings on barium enema study (Figs. 2A and 2B).

All 81 patients received a preoperative cephalosporin (Keflin or Ancef) and a minimum of three doses postoperatively. For suspected perforated appendices, anaerobic antibiotic coverage was given. Ninety-eight percent of the males received a right lower quadrant muscle splitting incision and 98% of the females received a right lower quadrant transverse incision. Sixty-one patients (75%) had primary closure of their wounds; 18 patients (22%) had delayed primary wound closure; and two patients (3%) had wound closure by secondary intention. Eight patients (10%) had penrose drainage

Graph 1.



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of the pelvis and right colon gutter. One patient required a tube cecostomy.

There were no mortalities and four infections (5%) — (2 wound and 2 intra-abdominal). Other complications were urinary retention, prolonged adynamic ileus, readmission for malaise, and hernia through the drain site, one of each. Microscopically, of the 81 patients with appendicitis, 7 patients (8.6%) had gangrene without perforation and 6 patients (7.4%) had perforation demonstrated.

Patients without Appendicitis

A total of 42 patients, thirteen males (31%) and 29 females (69%), did not have appendicitis. The percentage of patients responding to questions about their symptoms is listed in Table 5. The physical findings of these patients are listed in Table 6.

In 26 of 42 patients (62%), the WBC was greater than 10,000. Fully one third of the patients who submitted urinalyses (13 of 39 patients) had an abnormality present on examination. The most common abnormality was an elevated number of white blood cells

TABLE 3

Patients with Appendicitis
(Total of 81 pts.)

<u>Symptoms</u>		
	<u>N/number responding</u>	<u>% (of pts. responding)</u>
Epigastric +/- periumbilical pain	67/80	84
Nausea +/- vomiting	68/80	85
Loss of appetite	57/67	85
Movement of pain to RLQ	56/69	81
Pain started in RLQ	8/69	12



Figure 1A.



Figure 1B.

TABLE 4

Patients with Appendicitis
(Total of 81)

Physical Findings

	<u>Number</u>	<u>%</u>
RLQ abd. tenderness	80 pts.	98.7
Peritoneal irritation in RLQ of abd.	68 pts.	84
Temp. greater than or equal to 100°	21 pts.	26

TABLE 5

Non Appendicitis Patients
(total of 42 pts.)

	<u>Symptoms</u>	
	<u>N/number responding</u>	<u>% of pts responding</u>
Epigastric +/- peri umbilical pain	25/41	61%
Nausea +/- vomiting	28/41	71%
Loss of appetite	31/32	97%
Movement of pain to RLQ	17/39	44%
Pain started in RLQ	11/39	28%

and bacteria. Four of 39 patients (10%) had ketones in their urine.

The management of these 42 patients was the same as those who had appendicitis. Only three patients had delayed primary wound closure. There were two infections — (one wound and one pelvic hematoma).

Patients without Appendicitis

What did they have?

The final diagnoses among the males and females without appendicitis and shown in Table 7 and Table 8 respectively. The three patients with the asterisk (*) beside their diagnoses obviously benefited greatly from their surgery.

Discussion

History

When comparing patients with gastroenteritis, mesenteric adenitis, and abdominal pain of uncertain origin, (9 males and 16 females), the literature does not

seem to define a reliable difference in the symptoms of a) duration of illness prior to presentation and b) presence of anorexia, nausea, and vomiting — when compared to patients with appendicitis.

Pain *starting in* the right lower quadrant of the abdomen has been documented in the literature as occurring more commonly in patients with right lower

quadrant pathology other than appendicitis — when compared to patients who did have appendicitis. In this series the pain starting in the right lower quadrant was 2.5 times more frequent in nonappendicitis patients than in those patients with appendicitis.

Patients with pelvic inflammatory disease usually have a longer duration of symptoms, fewer gastrointestinal symptoms, onset of symptoms in the first third of the menstrual cycle and have cervical tenderness and often bilateral lower abdominal tenderness on examination.

TABLE 6

Non Appendicitis Patients
(total of 42 pts.)

Physical Findings

	<u>number</u>	<u>%</u>
RLQ abd. tenderness	37	88%
Peritoneal irritation in RLQ of abd.	28	67%
T greater than or equal to 100°	15	36%

History and White Blood Cell Count

Of the eighty one patients with appendicitis, only seven had a WBC less than 10,000 and one of these had been on antibiotics for a week for a presumed kidney infection. Of the remaining six patients, all had a classic or near classic history for appendicitis, and all had right lower quadrant peritoneal irritation on examination. Their convincing histories and physical findings outweighed their normal white blood cell counts and prompted surgery.

Urinalysis

One man had 200 RBC/h.p.f. in his urine along with a good history and examination for appendicitis. His appendix was normal, and his renal cell carcinoma



Figure 2A.



Figure 2B.

TABLE 7

Non Appendicitis Patients
(total of 42 pts.)

What did they have?

Males (N=13)

Mesenteric adenitis	4 pts.
Gastroenteritis	3 pts.
Abd. pain-unc. origin	2 pts.
Renal cell car. rt. kidney	1 pt.
Febrile illness mim.app.	1 pt.
Acute focal peri app.	1 pt.
*Perf. sigm.colon divert.	1 pt.

was removed later the same admission. Five women having normal appendices removed had documented urinary tract infections from cultures obtained either pre- or post-operatively. Their urinalyses showed 4 to 6 up to 50 WBC/h.p.f. with moderate to large numbers of bacteria.

An article from *Archives of Surgery* in 1963 looked at the urine sediment in 113 patients with appendicitis. Two sentences from the article are worthy of quotation.

No patient was found to have more than 30 red cells or 20 white cells with occasional clumps in a centrifuged specimen of voided urine. Serious consideration should be given to a diagnosis of urinary tract pathology in patients with questionable signs of acute appendicitis if unusually large numbers of cells are found on urinalysis.³

Summary

After reviewing all 123 of these patients, here are some suggestions which may improve the accuracy of diagnosis of appendicitis.

1. Proceed slowly with any patient with equivocal history and physical exam +/- WBC less than 10,000.

2. Seriously consider U.T.I. or other renal pathology in patients with greater than 20 RBC +/- or greater than 30 WBC/hfp (w/bacteria) as cause of RLQ pain, rather than appendicitis; *i.e.* only 1 of 81 patients with appendicitis had a coexistent U.T.I.

3. Be aware that pain *starting* in the RLQ is less common in appendicitis than in other conditions mimicking appendicitis.

4. Be wary of all women presenting with RLQ pain on days 1 through 10 of their menstrual cycle.

5. Consider a barium swallow or enema study in patients in categories 1-4 above looking for a *normally*

TABLE 8

Non Appendicitis Patients
(total of 42 pts.)

What did they have?

Females (N=29)

Cause undetermined +/- or gastroenteritis	15 pts.
U.T.I.	5 pts.
P.I.D.	2 pts.
Mesenteric adenitis	1 pt.
Bleeding rt.ovarian cyst	1 pt.
Recurring RLQ pain (clinically chronic app.)	2 pts
Omental infarction	1 pt.
*R peritubular abscess	1 pt.
*Torsion of rt. tube + ovary with gangrene	1 pt.

filled appendix while a) observing patient and b) awaiting outstanding lab results (*i.e.* ur. cult., cerv. os cult., etc.).

6. Follow closely all patients in all of the above categories and operate for worsening condition.

7. Require classic or near classic history and physical findings in patients with WBC less 10,000 suspected of having appendicitis, prior to surgery.

Footnotes to these suggestions are as follows:

1. Understand that following these suggestions may result in an increase in the incidence of perforation coincident with an increase in diagnostic accuracy.

2. Be less hesitant to operate on patients over 50 y.o. because of a) their frequent atypical presentations, and b) the known higher incidence of perforation in this age group.

3. Be less hesitant to operate on children because of their frequent later presentation to the doctor with appendicitis and therefore with an associated higher incidence of perforation.

Acknowledgements

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DESCRIPTION

Meperidine hydrochloride is ethyl 1-methyl-4-phenylisopropylcarbamate hydrochloride, a white crystalline substance with a melting point of 186°C to 189°C. It is readily soluble in water and has a neutral reaction and a slightly bitter taste. The solution is not decomposed by a short period of boiling.

The syrup is a pleasant-tasting, nonalcoholic, banana-flavored solution containing 50 mg of DEMEROL hydrochloride, brand of meperidine hydrochloride, per 5 mL teaspoon (25 drops contain 13 mg of DEMEROL hydrochloride). The tablets contain 50 mg or 100 mg of the analgesic.

DEMOROL hydrochloride injectable is supplied in Carpuject[®] Sterile Cartridge-Needle Unit of 2.5% (25 mg/1 mL), 5% (50 mg/1 mL), 7.5% (75 mg/1 mL), and 10% (100 mg/1 mL). Uni-Amp[®] Unit Dose Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Uni-Nest[™] Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Multiple-dose vials of 5% and 10% solutions contain metacresol 0.1% as preservative.

The pH of DEMOROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid.

DEMOROL hydrochloride, brand of meperidine hydrochloride, 5 percent solution has a specific gravity of 1.0086 at 20°C and 10 percent solution, a specific gravity of 1.0165 at 20°C.

Inactive Ingredients — TABLETS: Calcium Sulfate, Dibasic Calcium Phosphate, Starch, Stearic Acid, Talc, SYRUP: Benzoic Acid, Flavor, Liquid Glucose, Purified Water, Saccharin Sodium.

CLINICAL PHARMACOLOGY

Meperidine hydrochloride is a narcotic analgesic with multiple actions qualitatively similar to those of morphine, the most prominent of these involve the central nervous system and organs composed of smooth muscle. The principal actions of therapeutic value are analgesia and sedation.

There is some evidence which suggests that meperidine may produce less smooth muscle spasm, constipation, and depression of the cough reflex than equianalgesic doses of morphine. Meperidine, in 60 mg to 80 mg parenteral doses, is approximately equivalent in analgesic effect to 10 mg of morphine. The onset of action is slightly more rapid than with morphine, and the duration of action is slightly shorter. Meperidine is significantly less effective by the oral than by the parenteral route, but the exact ratio of oral to parenteral effectiveness is unknown.

INDICATIONS AND USAGE

For the relief of moderate to severe pain (parenteral and oral forms)
For preoperative medication (parenteral form only)
For support of anesthesia (parenteral form only)
For obstetrical analgesia (parenteral form only)

CONTRAINDICATIONS

Hypersensitivity to meperidine.

Meperidine is contraindicated in patients who are receiving monoamine oxidase (MAO) inhibitors or those who have recently received such agents. Therapeutic doses of meperidine have occasionally precipitated unpredictable, severe, and occasionally fatal reactions in patients who have received such agents within 14 days. The mechanism of these reactions is unclear, but may be related to a preexisting hyperphenylalaninemia. Some have been characterized by coma, severe respiratory depression, cyanosis, and hypotension, and have resembled the syndrome of acute narcotic overdose. In other reactions the predominant manifestations have been hyperexcitability, convulsions, tachycardia, hyperpyrexia, and hypertension. Although it is not known that other narcotics are free of the risk of such reactions, virtually all of the reported reactions have occurred with meperidine. If a narcotic is needed in such patients, a sensitivity test should be performed in which repeated, small, incremental doses of morphine are administered over the course of several hours while the patient's condition and vital signs are under careful observation. (Intravenous hydrocortisone or prednisolone have been used to treat severe reactions, with the addition of intravenous chlorpromazine in those cases exhibiting hypertension and hyperpyrexia. The usefulness and safety of narcotic antagonists in the treatment of these reactions is unknown.)

Solutions of DEMOROL and barbiturates are chemically incompatible.

WARNINGS

Drug Dependence Meperidine can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of meperidine, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Like other narcotics, meperidine is subject to the provisions of the Federal narcotic laws.

Interaction with Other Central Nervous System Depressants MEPERIDINE SHOULD BE USED WITH GREAT CAUTION AND IN REDUCED DOSAGE IN PATIENTS WHO ARE CONCURRENTLY RECEIVING OTHER NARCOTIC ANALGESICS, GENERAL ANESTHETICS, PHENOTHIAZINES, OTHER TRANQUILIZERS (SEE DOSAGE AND ADMINISTRATION), SEDATIVE-HYPNOTICS (INCLUDING BARBITURATES), TRICYCLIC ANTIDEPRESSANTS AND OTHER

CNS DEPRESSANTS (INCLUDING ALCOHOL), RESPIRATORY DEPRESSION, HYPOTENSION, AND PROFOUND SEDATION OR COMA MAY RESULT.

Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of meperidine and its capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. In such patients, meperidine must be used with extreme caution and only if its use is deemed essential.

Intravenous Use. If necessary, meperidine may be given intravenously, but the injection should be given very slowly, preferably in the form of a diluted solution. Rapid intravenous injection of narcotic analgesics, including meperidine, increases the incidence of adverse reactions; severe respiratory depression, apnea, hypotension, peripheral circulatory collapse, and cardiac arrest have occurred. Meperidine should not be administered intravenously unless a narcotic antagonist and the facilities for assisted or controlled respiration are immediately available. When meperidine is given parenterally, especially intravenously, the patient should be lying down.

Asthma and Other Respiratory Conditions. Meperidine should be used with extreme caution in patients having an acute asthmatic attack, patients with chronic obstructive pulmonary disease or cor pulmonale, patients having a substantially decreased respiratory reserve, and patients with preexisting respiratory depression, hypoxia, or hypercapnia. In such patients, even usual therapeutic doses of narcotics may decrease respiratory drive while simultaneously increasing airway resistance to the point of apnea.

Hypotensive Effect. The administration of meperidine may result in severe hypotension in the postoperative patient or any individual whose ability to maintain blood pressure has been compromised by a depleted blood volume or the administration of drugs such as the phenothiazines or certain anesthetics.

Usage in Ambulatory Patients. Meperidine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient should be cautioned accordingly.

Meperidine, like other narcotics, may produce orthostatic hypotension in ambulatory patients.

Usage in Pregnancy and Lactation. Meperidine should not be used in pregnant women prior to the labor period, unless in the judgment of the physician the potential benefits outweigh the possible hazards, because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development.

When used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce depression of respiration and psychophysiological functions in the newborn. Resuscitation may be required (see section on OVERDOSAGE).

Meperidine appears in the milk of nursing mothers receiving the drug.

PRECAUTIONS

As with all intramuscular preparations DEMOROL intramuscular injection should be injected well within the body of a large muscle.

Supraventricular Tachycardias. Meperidine should be used with caution in patients with atrial flutter and other supraventricular tachycardias because of a possible vagolytic action which may produce a significant increase in the ventricular response rate.

Convulsions. Meperidine may aggravate preexisting convulsions in patients with convulsive disorders. If dosage is escalated substantially above recommended levels because of tolerance development, convulsions may occur in individuals without a history of convulsive disorders.

Acute Abdominal Conditions. The administration of meperidine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients. Meperidine should be given with caution and the initial dose should be reduced in certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS

The major hazards of meperidine, as with other narcotic analgesics, are respiratory depression and, to a lesser degree, circulatory depression; respiratory arrest, shock, and cardiac arrest have occurred.

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea, vomiting, and sweating. These effects seem to be more prominent in ambulatory patients and in those who are not experiencing severe pain. In such individuals, lower doses are advisable. Some adverse reactions in ambulatory patients may be alleviated if the patient lies down.

Other adverse reactions include

Nervous System: Euphoria, dysphoria, weakness, headache, agitation, tremor, uncoordinated muscle movements, severe convulsions, transient hallucinations and disorientation, visual disturbances. Inadvertent injection about a nerve trunk may result in sensory-motor paralysis which is usually, though not always, transitory.

Gastrointestinal: Dry mouth, constipation, biliary tract spasm.

Cardiovascular: Flushing of the face, tachycardia, bradycardia, palpitation, hypotension (see Warnings), syncope, phlebitis following intravenous injection.

Genitourinary: Urinary retention.

Allergic: Pruritus, urticaria, other skin rashes, wheal and flare over the vein with intravenous injection.

Other: Pain at injection site, local tissue irritation and induration following subcutaneous injection, particularly when repeated, anti-diuretic effect.

DOSAGE AND ADMINISTRATION

For Relief of Pain

Dosage should be adjusted according to the severity of the pain and the response of the patient. While subcutaneous administration is suitable for occasional use, intramuscular administration is preferred when repeated doses are required. If intravenous administration is required, dosage should be decreased and the injection made

very slowly, preferably utilizing a diluted solution. Meperidine is less effective orally than on parenteral administration. The dose of DEMOROL should be proportionately reduced (usually by 25 to 50 percent) when administered concomitantly with phenothiazines and many other tranquilizers since they potentiate the action of DEMOROL.

Adults. The usual dosage is 50 mg to 150 mg intramuscularly, subcutaneously, or orally, every 3 or 4 hours as necessary.

Children. The usual dosage is 0.5 mg/lb to 0.8 mg/lb intramuscularly, subcutaneously, or orally up to the adult dose, every 3 or 4 hours as necessary.

Each dose of the syrup should be taken in one-half glass of water, since if taken undiluted, it may exert a slight topical anesthetic effect on mucous membranes.

For Preoperative Medication

Adults. The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously, 30 to 90 minutes before the beginning of anesthesia.

Children. The usual dosage is 0.5 mg/lb to 1 mg/lb intramuscularly or subcutaneously up to the adult dose, 30 to 90 minutes before the beginning of anesthesia.

For Support of Anesthesia

Repeated slow intravenous injections of fractional doses (eg, 10 mg/mL) or continuous intravenous infusion of a more dilute solution (eg, 1 mg/mL) should be used. The dose should be titrated to the needs of the patient and will depend on the premedication and type of anesthesia being employed, the characteristics of the particular patient, and the nature and duration of the operative procedure.

For Obstetrical Analgesia

The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously when pain becomes regular, and may be repeated at 1- to 3-hour intervals.

OVERDOSAGE

Symptoms: Serious overdose with meperidine is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonist, naloxone hydrochloride, is a specific antidote against respiratory depression which may result from overdose or unusual sensitivity to narcotics, including meperidine. Therefore, an appropriate dose of this antagonist should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

In cases of overdose with DEMOROL tablets, the stomach should be evacuated by emesis or gastric lavage.

NOTE: In an individual physically dependent on narcotics, the administration of the usual dose of a narcotic antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of narcotic antagonists in such individuals should be avoided if possible. If a narcotic antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care and only one-fifth to one-tenth the usual initial dose administered.

HOW SUPPLIED

For Parenteral Use

Detecto-Seal[®] — Carpuject[®] Sterile Cartridge-Needle Unit — 2.5 percent (25 mg per 1 mL) **NDC 0024-0324-02**, 5 percent (50 mg per 1 mL) **NDC 0024-0325-02**, 7.5 percent (75 mg per 1 mL) **NDC 0024-0326-02**; and 10 percent (100 mg per 1 mL) **NDC 0024-0328-02** all in boxes of 10.

Each cartridge is only partially filled based upon product volume to permit mixture with other sterile materials in accordance with the best judgment of the physician.

Uni-Amp[®] — 5 percent solution: ampuls of 0.5 mL (25 mg) **NDC 0024-0361-04**, 1 mL (50 mg) **NDC 0024-0362-04**, 1½ mL (75 mg) **NDC 0024-0363-04**, and 2 mL (100 mg) **NDC 0024-0364-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0365-04** in boxes of 25.

Uni-Nest[™] — 5 percent solution: ampuls of 0.5 mL (25 mg) **NDC 0024-0371-04**, 1 mL (50 mg) **NDC 0024-0372-04**, 1½ mL (75 mg) **NDC 0024-0373-04**, and 2 mL (100 mg) **NDC 0024-0374-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0375-04** in boxes of 25.

Vials — 5 percent multiple-dose vials of 30 mL **NDC 0024-0329-01**, and 10 percent multiple-dose vials of 20 mL **NDC 0024-0331-01** all in boxes of 1.

Note: The pH of DEMOROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid. Multiple-dose vials contain metacresol 0.1 percent as preservative. No preservatives are added to the ampuls or CARPUJECT Sterile Cartridge-Needle Unit.

For Oral Use

Tablets of 50 mg, bottles of 100 (**NDC 0024-0335-04**) and 500 (**NDC 0024-0335-06**); Hospital Blister Pak of 25 (**NDC 0024-0335-02**); 100 mg, bottles of 100 (**NDC 0024-0337-04**) and 500 (**NDC 0024-0337-06**); Hospital Blister Pak of 25 (**NDC 0024-0337-02**).

Syrup, nonalcoholic, banana-flavored 50 mg per 5 mL teaspoon, bottles of 16 fl oz (**NDC 0024-0332-06**).

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Division of Sterling Drug Inc.
New York, NY 10016

Intracranial Hemorrhage Associated with Quinidine Induced Thrombocytopenia

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J. J. McCloskey, M.D.*

Abstract

Quinidine is commonly used in the treatment of atrial and ventricular arrhythmias. Such patients are at increased risk for embolic strokes and may require concurrent anticoagulation therapy. We report here the occurrence of intracranial hemorrhage as a complication of thrombocytopenia in two patients on quinidine.

Introduction

Intracranial hemorrhage is an unusual, and not previously reported complication of quinidine induced thrombocytopenia. Other drugs may potentiate the bleeding tendency of patients with quinidine induced thrombocytopenia. Both of our patients were on such drugs (warfarin in one case, aspirin in the other). Common complications of thrombocytopenia, such as petechiae, bleeding gums, melena, and easy bruising are well known and should be watched for in patients taking these drugs.¹ The purpose of this article is to draw attention to intracranial hemorrhage (ICH) as a complication of concurrent use of quinidine and warfarin or aspirin.

Case One: The first patient is a 76-year-old black female who presented November 1, 1988 with a two day history of gum bleeding and easy bruising. She

has a past history of a deep venous thrombosis with inferior vena cava extension and prophylactic Greenfield filter placed in February 1988. She was placed on warfarin at that time and was taking 5 mg/day at admission. She had ventricular tachyarrhythmias diagnosed in September 1988 and was placed on quinidine sulfate (300 mg. every six hours). Physical examination revealed ecchymotic areas, petechiae, and irregular cardiac rhythm. She had occult blood in her stool. Neurologic exam revealed a left sided facial weakness consistent with a right central VII cranial nerve palsy and generalized weakness.

Laboratory studies revealed a PT of 15.7 sec. (normal range 10.5 to 12.9 seconds), PTT of 25 sec. (normal range 21 to 35 seconds), hematocrit of 44.5%, and white blood cell count of 6.8 thousand per cubic millimeter. She had an initial platelet count of 10,000 per cubic millimeter. Quinidine level was 0.8 mg/ml. Bone marrow aspirate revealed the presence of megakaryocytes. Computed tomography of the brain revealed an acute hemorrhage in the area of the left basal ganglia. (Figure 1)

The patient was taken off of the quinidine and warfarin and was treated with intravenous gamma globulins with good response (platelets increased to 400,000 per cubic millimeter within 10 days). Her hospital course was complicated by a pulmonary embolism requiring resumed anticoagulation. She had good recovery, returning to baseline level of function by the time of discharge.

Case Two: The second patient was a 57-year-old white male, who presented in February, 1989, with

continued on page 24

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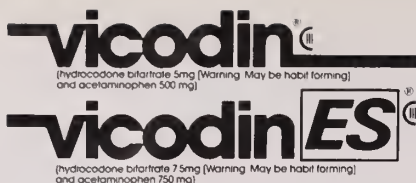
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2. Standard industry new prescription audit.

Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdosage may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981



Intracranial Hemorrhage

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headache, nausea, and right hemiparesis progressing to coma. He had a past medical history of coronary artery bypass one month previously and his routine medicines included digoxin, verapamil, quinidine, and aspirin. The patient had a spontaneous nose bleed the previous day.

Laboratory studies revealed a platelet count of 4,000 per cubic millimeter. His PT and PTT were normal. Computed tomography revealed a large left frontal-temporal intracerebral hematoma (Figure 2). Carotid arteriogram did not show any evidence of aneurysm, AVM, or brain tumor.

The patient's condition continued to deteriorate. He was given steroids, immunoglobulins, and platelets in attempts to control his coagulopathy prior to emergency surgery. These attempts were unsuccessful and a craniotomy to evacuate the hematoma did not slow

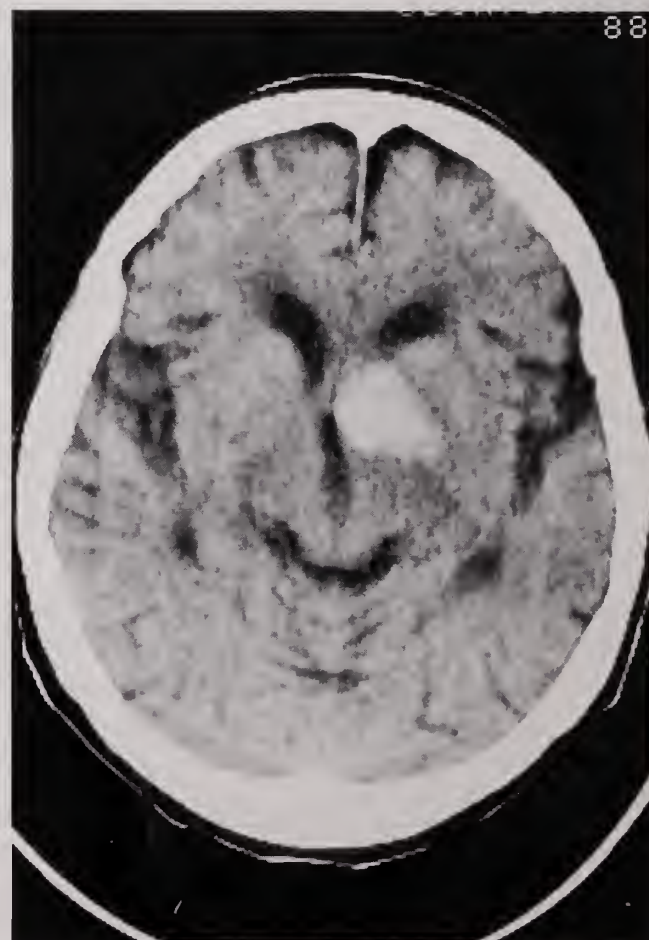


Figure 1. An axial CT section shows a hematoma in the basal ganglia area on the left which involves the anterior and posterior limb of the internal capsule as well as the genu. There is displacement of the anterior third ventricle across the midline.

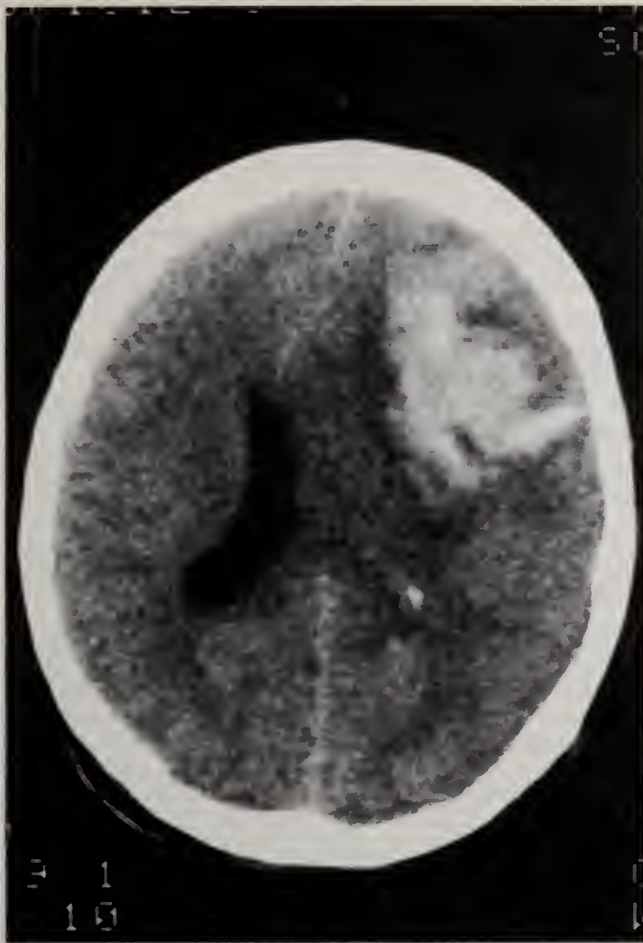


Figure 2. An axial CT section shows a hematoma in the left frontal lobe which is compressing the left lateral ventricle and displacing the midline from left to right.

the patient's deterioration. He expired the day following admission.

Discussion

Thrombocytopenia is a well documented complication of quinidine therapy, which is felt to be secondary to an antiplatelet antibody.² Thrombocytopenia (as well as warfarin therapy) is a risk factor for bleeding complications including intracranial hemorrhage (ICH).³ The most common ICH in patients on Coumadin is a subdural hemorrhage.⁴ Quinidine is frequently used in the therapy of atrial and ventricular arrhythmia. These same arrhythmias may also predispose the patient to embolic strokes from cardiac intraventricular or intra-atrial clots. The presence or possibility of such cardiac sources of emboli may require chronic anticoagulation therapy of which warfarin is the most frequently used. Aspirin is a commonly used medicine, especially in patients at risk for myocardial infarction or ischemic stroke and is a well known cause of functional abnormalities of platelets.

Perhaps the most serious complication of thrombocytopenia is ICH.^{5,6} Such patients may present as a catastrophic neurologic event or with minimal symptoms. The hemorrhage may occur without any history of trauma. Idiopathic thrombocytopenia purpura (ITP) has been reported to be associated with ICH,⁷ but quinidine induced thrombocytopenia leading to ICH has not been previously documented.

Management of such patients requires cessation of all possible offending drugs and ruling out other possible causes of thrombocytopenia (such as autoimmune conditions including systemic lupus erythematosus). If the situation is critical or the thrombocytopenia is persistent, platelet transfusions or treatment with gamma globulins may be pursued.⁸

The treatment of the ICH would depend on its severity and may entail measures to combat raised intracranial pressure. Such measures might include elevating the head of the bed, fluid restriction, use of mannitol, and mechanical ventilation with hyperventilation and other traditional treatments of raised intracranial pressure.⁹

We have presented two cases in which a patient being simultaneously treated with both warfarin and quinidine and another patient on aspirin and quinidine developed bleeding complications including intracranial hemorrhage. These cases draw attention to the need for close follow-up of patients on quinidine and either of these medicines. Mild elevation in PT and normal PTT in the first patient suggests minimal inhibition of coagulation by Coumadin which was probably exacerbated by the severe thrombocytopenia associated with quinidine. Aspirin therapy in the second patient with quinidine-induced thrombocytopenia probably exaggerated his bleeding problems. The addition of quinidine to warfarin, or even aspirin, should alert the physician to the possibility of thrombocytopenia and the platelet count should be closely followed in addition to close monitoring for signs and symptoms of coagulopathies. □

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The Stylebook/Editorial Manual, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E. B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged. Second Edition.

Length of articles: Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

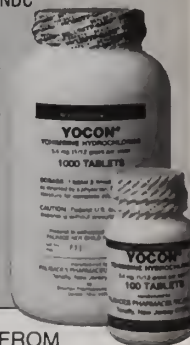
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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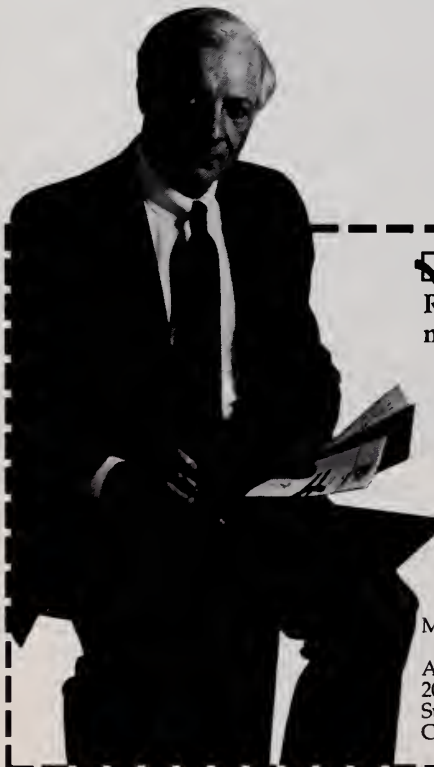
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Mrs. John O. Hardiman
A-MASA President

Adolescent Health AMA Clinical Update

Support of the AMA Adolescent Health Initiative remains a top priority of the American Medical Association Auxiliary. The AMA Auxiliary Health Projects Committee has sent to each state auxiliary president a video produced by the AMA on teen suicide, substance abuse, and sexuality, and how they are affecting the health of our nation's youth. This video, entitled "AMA Clinical Update: Adolescent Health" was shown on the American Medical Association's cable television program, and is a continuing medical education activity for one hour of Category I CME credit, provided that it is completed with the program evaluation.

With the permission of the AMAA, my husband has made two copies of this tape, and I am sending one copy to Terri Glasgow, A-MASA's Health Projects Chairman, 3009 Brookwood Road, Birmingham, AL 35223, and one copy to Ginny Mosley, 71 Byrnes Blvd., Mobile, AL 36608, A-MASA's Adolescent Health Chairman, and I will keep one copy. These are available for any medical group to borrow to educate themselves, auxiliary members, other community leaders, school administrators, parents, and church officials about the problems facing adolescents today. Please contact one of us if you wish to view and show this video.

Following are some excerpts from the study guide, and some of the facts are quite alarming.

"Adolescence is defined as the period between childhood and adulthood. During this transitional period adolescents are physically and mentally changing and are susceptible to pressures to experiment with, among other things, alcohol, drugs and emerging sexual feelings. Other adolescents are likely to engage in deviant behavior, and some may decide to run away from home, thus exposing themselves to abuse and victimization by strangers. Most tragically, some young adults, unable to cope with seemingly insurmountable problems, choose suicide.

"According to the AMA's White Paper on Adolescent Health both morbidity and mortality rates for adolescents are 11% higher today than they were 20 years ago. Factors responsible for this increase include:

Substance Abuse

- *Two-thirds* of American youth use an illicit drug before they finish high school, and *one in five* high school seniors smoke cigarettes daily.
- *One in 16* high school seniors drinks alcoholic beverages DAILY, and 41% report that they have consumed *five or more drinks on one occasion*.

Sexuality/Pregnancy

- Teenage mothers account for *46% of all births* to unmarried women and a *third of all abortions*.

continued on next page

- *Two-thirds* of all sexually active adolescent girls do not routinely use birth control.
- Maternal mortality is *2.5 times higher in girls under age 15* than in women in their twenties.

Victimization

- 24% of all *fatalities* and 41% of all *serious injuries* in reported cases of physical abuse involve **PERSONS AGED 12 TO 17**.
- 6% of ALL BOYS and 15% of GIRLS experience **SEXUAL ABUSE** by the AGE OF 16.
- *Half of all rape victims are less than 18 years of age.*
- 600,000 teenage GIRLS and 300,000 BOYS work as PROSTITUTES; their AVERAGE AGE IS 15.

Psychological Disorders/Suicide

- 5,000 persons UNDER AGE 19 commit *suicide* each year, and 50,000 attempt it.
- Up to 2.4% of teenage girls suffer from anorexia nervosa and as many as 8%-15% are bulimic.

Violence/Trauma

- 80% of deaths in 15- to 24-year-olds are secondary to accidents, suicides, and homicides.
- Adolescents are *responsible* for a *third* of all violent crimes.

"Despite a myriad of signs and symptoms that may be obvious when treating adolescents, physicians must develop open lines of communication between themselves and adolescent patients so that adolescents feel comfortable confiding in their physician. In order to nurture a sense of trust, physicians must speak frankly and nonjudgmentally when obtaining medical histories. For instance, adolescents want to know about their bodies and the physical changes they are experiencing. When adolescent patients ask questions about their emerging sexuality, they want to know the facts. Physicians treating adolescents must be prepared to answer these questions factually. Also, physicians must be prepared to initiate a conversation on these and other topics if the adolescent indicates, through nonverbal communications or other signals, that such a conversation may be appropriate.

"In addition to offering the facts to adolescents, physicians must ensure the patient's confidentiality. Although most adolescents are legally under the supervision of their parents or guardians, adolescent patients must KNOW that anything they say to their physicians will remain confidential, unless they are in danger to themselves or to others.

"In order to treat adolescents, physicians need to remain updated on specific information covering such topics as substance abuse, teenage sexuality, victimization, depression, suicide, and violence."

The above statements and statistics are not the most up-lifting in the world, are they? Yet, if we are to help

our adolescents, we must face the facts as they are, and act accordingly. We cannot observe the adolescents who "have it altogether," and say that everything is great. Sometimes it is someone in our immediate or extended family that needs help, and we — or they — are the last to realize it. And, sometimes, sadly enough, it is the adolescent that belongs to the physician that needs the most help! A number of factors increase this possibility, including too little family involvement of physician and/or spouse and too much money available.

We all want the very best life possible for ALL adolescents, and I do not mean material possessions. I am speaking of health, security, and happiness in whatever each undertakes during his/her lifetime. One adolescent health worry in Alabama of which we all are aware is teenage pregnancy. Perhaps if we could educate more youngsters earlier about sexual matters, we could decrease the incidence of teenage pregnancy in Alabama, but this brings up the question of family versus school, different religious beliefs, and certainly opens up Pandora's Box!

For the second year the AMA Auxiliary is working in coalition with the American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG) on their public education campaign regarding teen pregnancy prevention. Last year's campaign focused on the teenage female, and this year's focuses on the male's responsibility. It includes radio and television public service announcements (PSA), and a brochure entitled "Straight Facts for Men About Sex." Watch for these announcements: they will certainly get the attention of adolescents! CBS, NBC, and ABC have already approved them for showing. The tape of last year entitled "Myths," part of the campaign to educate girls, is included in the tape sent to stations for broadcasting/viewing. ACOG has available two pamphlets — "The Facts" and "Straight Facts for Men About Sex" — and posters to promote the teen pregnancy prevention message, and these are available in packages of 50 (free of charge) from: Public Information, The American College of Obstetricians and Gynecologists, 409 12th Street, SW, Washington, DC 20024-2188, if you wish to distribute them to young people in your community. Our Medical Societies and Auxiliaries can make an important contribution to our youth by joining in this campaign.

Easy solutions? NO. Our problems? YES. We MUST find out what we can do to help our adolescents, and take the action necessary to help them. □

Martha Anne



VASOTEC®

(ENALAPRIL MALEATE) MSD

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: **General: Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See PRECAUTIONS, Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rats. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (30 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Dther: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Dther (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: Hypertension. In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium. (See PRECAUTIONS.)

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance <30 mL/min (serum creatinine >3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19386.

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Despite All, Medicine Is Blessed

see page 9

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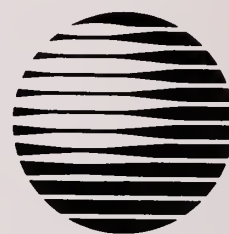
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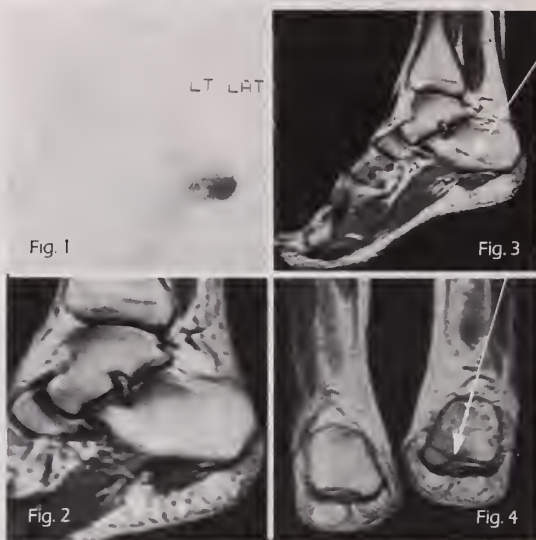
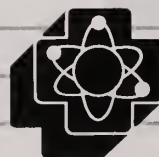


Fig. 1. Limited bone scintigram reveals abnormal tracer uptake in left calcaneus.
Fig. 2. Normal homogeneous signal intensity of marrow in right calcaneus.
Fig. 3 and 4. Sagittal and coronal (T2 [2000/30]) MRI images of left calcaneus reveal bands of signal void suggesting intraosseous fracture.



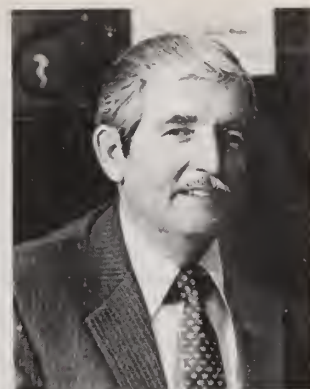
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Design For Mediocrity

Some months ago (*Alabama Medicine*, May 1989) I paid tribute to some current examples of the survival of rugged individualism in science, which I took to be heartening evidence that the trends toward bigness and collectivism had not entirely submerged the solitary genius working alone.

I mentioned the example of the astonishing achievements of two table-top scientists who demonstrated something long regarded as impossible — high temperature superconductivity, which may yet signal a new day for the world, although many problems remain in applying the/new science to the technology of resistance-free transmission of electric power. Japan has created an entirely new industrial consortium because of the American discovery, and this country is determined not to let Nippon have it all, as in the past.

Among the other examples of Lone Eagles suddenly coming back into the forefront of science was the much-maligned work of D. Stanley Pons, Ph.D., of the University of Utah, and his colleague, Martin Fleischmann, Ph.D., of the University of Southampton. The two chemists announced, earlier in the year, successful achievement of nuclear fusion at room temperature with an apparatus very similar to the one used to bronze baby shoes.

The Pons-Fleischmann report was roundly attacked as the work of crackpots. And none were more vociferous in their condemnation than particle physicists and their high-energy brethren, who look down their patrician noses at the claims of mere chemists. Physicists simply would not seriously entertain the preposterous idea that a couple of chemists could have

done what billions and billions of dollars and hundreds of physicists had not been able to do through decades of trying — to achieve a controlled fusion reaction that would last longer than a split second.

Fusion, the energy of the sun and stars, is seen as the energy of the future for man with his dwindling resources and increasing demands for power. For years, we have been told that fusion would produce power “too cheap to meter.” What could lowly chemists possibly contribute to this research?, physicists asked in derision, they whose science is increasingly linked with cosmology, The Big Bang, and how the universe was born.

Although I suspected at the time that the Pons-Fleischmann critics might be right for the wrong reasons, I reserved judgment until independent experts could have a dispassionate look at the cold fusion experiment. In July a 22-member panel convened by the U.S. Energy department reviewed the evidence then available and pronounced cold fusion had not occurred in any of the labs attempting it and that it was not a likely source of energy for the future.

Less than 90 days later, leading scientists attending a workshop sponsored by the prestigious National Science Foundation and the very pragmatic Electric Power Research Institute, said new findings from several top laboratories have now indicated that either a nuclear process or some new chemical process had to account for the heat and energy generated by replications of the Pons-Fleischmann experiment. The chairman of the workshop said:

“Based on the information that we have, these effects (the effects produced in independent laboratories)

cannot be explained as a result of artifacts, equipment error or human error."

The research should continue, the conference concluded. "Essentially," said one of the participants, "the evidence indicates the so-called cold fusion phenomenon is not dead."

Maybe the reason I find this announcement so gratifying is the David and Goliath dimension to the story — two humble chemists boldly challenging the rigid dogma of the powerful and dominant forces of the most esoteric (at least to me) of the sciences. But I believe there is still another ingredient: the historical fact that individual genius has always had a hard time of it with their contemporary power brokers in the sciences.

In my casual reading of science history, I see too many examples of the big putdown by the high and mighty when some solitary scientist has an apparent answer. Pasteur was dismissed as a nut by the establishment of his day. And how in the world could an English country doctor have the answer to smallpox, regarded by health authorities as perhaps the worst pandemic of all, considering total morbidity and mortality. But that is exactly what Edward Jenner did in 1796. He successfully inoculated a human guinea pig with cowpox, which provided protection against a subsequent injection of lethal matter from a smallpox eruption.

Dr. Jenner's paper describing the experiment was rejected as preposterous by the Royal Society. Published at his own expense, with additional data, Jenner's account of the experiment was replicated elsewhere. His name is today enshrined in the pantheon of benefactors of mankind, whereas the names of those who blackballed him at the Royal Society are forgotten.

There are, as all physicians know, countless other examples in the history of science and other human endeavors wherein official arrogance and inertia blocked progress. Today we see such arrogance abroad in medicine, as interlopers from the business schools and the computer science labs contend that the practice of medicine is really nothing more than a few algorithms that can be set down in software. With such robotics, they can tell doctors how to practice more efficiently (and, of course, more cheaply).

This is the brash new establishment of medicine — mostly laymen totally confident when they talk down to mere physicians. All this nonsense about each patient being different, that there is no such thing as an average case or an average treatment protocol, is just a smokescreen. They know better.

What any authoritarian establishment distrusts most is individualism. The Washington bureaucrats and the managed care experts are as one in their contempt for both the private practitioner and the individual patient. They are beginning to insist that every doctor and every

patient must conform with norms, averages and treatments by the book, the Bed of Procrustes.

Long before these whiz kids entered the picture, science has warned of the "tyranny of the norm," the distortions that result when averages are substituted for individual differences.

This is the same kind of establishment arrogance that almost denied the world the enormous contributions of such as Pasteur and Jenner.

Another victim of this arrogance was Ignaz Phillip Semmelweis, the Hungarian physician and surgeon serving as assistant obstetrician in Vienna General Hospital in the middle of the 19th century. His single-minded conviction that puerperal fever, or childbed fever, was caused by physicians themselves is a familiar story.

Less familiar is how Dr. Semmelweis was brutally ostracized for his views, even when he demonstrated that hand washing in a disinfectant dramatically reduced puerperal fever in Vienna. Denied promotion and professional status for his opinions, despite his record of success against the great killer of women, he was ultimately driven mad, dying in an insane asylum.

Even Oliver Wendell Holmes, M.D., the great American physician and author, failed to convince the opinion-makers of his profession that puerperal fever was both contagious and carried by physicians. His paper in the *New England Quarterly Journal of Medicine and Surgery* in April 1843 was flatly contradicted by the country's most influential academics, who said it was not contagious and in no case could it be carried by physicians.

Drs. Holmes and Semmelweis were ultimately vindicated, but the point is that the entire establishment in this country and Europe opposed them.

Herein lies the moral: conventional wisdom, whether of scientists or managed care folks, is not always right.

All too often in the history of science and medicine, conventional wisdom has proven to be conventional ignorance.

And this is what I fear most from the plethora of guidelines, parameters and protocols already becoming entrenched as the one true light. Medicine did not reach its present lofty pinnacle by regimentation, by lockstep herding, but by individuals with widely varying views on the ills of man, and from scores of different avenues. This, in fact, is the peculiar genius of the United States as a whole, given bedrock support by our Bill of Rights, designed by the nation's founders expressly to prevent imposed conformity by the central government.

The strength of American medicine, like the strength of the nation itself, derives from diversity, not conformity.

Former MASA President John B. McFerrin Rice, Jr., M.D., is given to respond to each new attempt at

regimentation with a singularly apt aphorism: "The denial of complexity is the beginning of tyranny."

And that is precisely the phenomenon at work now as the manipulative bureaucracy looks to HCFA for leadership in simplifying and standardizing what is acceptable in U.S. health care.

The bureaucrats and congressman have said and will continue to say (until stricken by honesty) that their objective is to improve the quality of health care. They will do this by reducing the quantity, a non-sequitur if there ever was one.

It would be one thing for the government to say that health care must be rationed because the American people will not pay for state of the art medicine for Medicare patients. Physicians could live with that. It's the dishonesty that galls, the attempt to make a virtue of necessity. Instead of saying the public is being protected from substandard care, the Feds should say the public is being protected from higher taxes and premiums that would be necessary if the rationing screws aren't constantly tightened.

That is at least honest. Add to it the unvarnished confession that regulated conformity, always seeking the lowest common denominator, is a function of cost control, and the Feds would have struck a blow for candor. That could be followed by the nation's political leadership telling Americans that if they want more health care they must pay for it in taxes and/or premiums. Otherwise, rationing will continue to cut deeper and deeper.

At some point this grim proposition must be put to the American people, but I'm not holding my breath. The modus operandi of Congress nowadays is to use smoke and mirrors to confuse the voters into believing that problems are being addressed when, in fact, they are being swept under the rug.

So let's not pretend that all of these quality controls are anything but infernal machines for cutting corners.

A necessary ingredient in the denial of complexity flowing from Washington is subjugation of individuals, doctors and patients alike, by converting disease processes, patients and physicians, and therapeutic modalities to software encryption. There was a time when Congress would have put down such un-American practices. But Congress, in the past 10 years, has shown little inclination to do other than follow the line of least resistance, delegating most of its authority to the vast and impersonal federal bureaucracy, the real rulers. I fear the effects of all this are predictable: the stifling of innovation and initiative, persistent reduction in both quality and quantity of health care — in short, the Sovietization of American medicine.

The weak link is Congress, which has abdicated its responsibility except to impose cuts. The result: the true establishment of U.S. health care is now HCFA. The private sector follows that lead, finding safety in numbers.

All this is the principal reason for the institution of MASA's Third Party Grievance Task Force. □

Lon

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DESCRIPTION

Meperidine hydrochloride is ethyl 1-methyl-4-phenylisopropylcarbamate hydrochloride, a white crystalline substance with a melting point of 186° C to 189° C. It is readily soluble in water and has a neutral reaction and a slightly bitter taste. The solution is not decomposed by a short period of boiling.

The syrup is a pleasant-tasting, nonalcoholic, banana-flavored solution containing 50 mg of DEMEROL hydrochloride, brand of meperidine hydrochloride, per 5 mL teaspoon (25 drops contain 13 mg of DEMEROL hydrochloride). The tablets contain 50 mg or 100 mg of the analgesic.

DEMOROL hydrochloride injectable is supplied in Carpuject[®] Sterile Cartridge-Needle Unit of 2.5% (25 mg 1 mL), 5% (50 mg 1 mL), 7.5% (75 mg 1 mL), and 10% (100 mg 1 mL). Uni-Amp[®] Unit Dose Pak — ampuls of 5% solution (25 mg 0.5 mL), (50 mg 1 mL), (75 mg 1.5 mL), (100 mg 2 mL), and 10% solution (100 mg 1 mL), (150 mg 1.5 mL), (200 mg 2 mL), and 10% solution (100 mg 1 mL). Multiple-dose vials of 5% and 10% solutions contain metacresol 0.1% as preservative.

The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid.

DEMOROL hydrochloride, brand of meperidine hydrochloride, 5 percent solution has a specific gravity of 1.0086 at 20° C and 10 percent solution, a specific gravity of 1.0165 at 20° C.

Inactive Ingredients — TABLETS: Calcium Sulfate, Dibasic Calcium Phosphate, Starch, Stearic Acid, Talc. SYRUP: Benzoic Acid, Flavor, Liquid Glucose, Purified Water, Saccharin Sodium.

CLINICAL PHARMACOLOGY

Meperidine hydrochloride is a narcotic analgesic with multiple actions qualitatively similar to those of morphine, the most prominent of these involve the central nervous system and organs composed of smooth muscle. The principal actions of therapeutic value are analgesia and sedation.

There is some evidence which suggests that meperidine may produce less smooth muscle spasm, constipation, and depression of the cough reflex than equianalgesic doses of morphine. Meperidine, in 60 mg to 80 mg parenteral doses, is approximately equivalent in analgesic effect to 10 mg of morphine. The onset of action is slightly more rapid than with morphine, and the duration of action is slightly shorter. Meperidine is significantly less effective by the oral than by the parenteral route, but the exact ratio of oral to parenteral effectiveness is unknown.

INDICATIONS AND USAGE

For the relief of moderate to severe pain (parenteral and oral forms)
For preoperative medication (parenteral form only)
For support of anesthesia (parenteral form only)
For obstetrical analgesia (parenteral form only)

CONTRAINDICATIONS

Hypersensitivity to meperidine.

Meperidine is contraindicated in patients who are receiving monoamine oxidase (MAO) inhibitors or those who have recently received such agents. Therapeutic doses of meperidine have occasionally precipitated unpredictable, severe, and occasionally fatal reactions in patients who have received such agents within 14 days. The mechanism of these reactions is unclear, but may be related to a preexisting hyperphenylalaninemia. Some have been characterized by coma, severe respiratory depression, cyanosis, and hypotension, and have resembled the syndrome of acute narcotic overdose. In other reactions the predominant manifestations have been hyperexcitability, convulsions, tachycardia, hyperpyrexia, and hypertension. Although it is not known that other narcotics are free of the risk of such reactions, virtually all of the reported reactions have occurred with meperidine. If a narcotic is needed in such patients, a sensitivity test should be performed in which repeated, small, incremental doses of morphine are administered over the course of several hours while the patient's condition and vital signs are under careful observation. (Intravenous hydrocortisone or prednisolone have been used to treat severe reactions, with the addition of intravenous chlorpromazine in those cases exhibiting hypertension and hyperpyrexia. The usefulness and safety of narcotic antagonists in the treatment of these reactions is unknown.)

Solutions of DEMEROL and barbiturates are chemically incompatible.

WARNINGS

Drug Dependence. Meperidine can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of meperidine, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Like other narcotics, meperidine is subject to the provisions of the Federal narcotic laws.

Interaction with Other Central Nervous System Depressants. MEPERIDINE SHOULD BE USED WITH GREAT CAUTION AND IN REDUCED DOSAGE IN PATIENTS WHO ARE CONCURRENTLY RECEIVING OTHER NARCOTIC ANALGESICS, GENERAL ANESTHETICS, PHENOTHIAZINES, OTHER TRANQUILIZERS (SEE DOSAGE AND ADMINISTRATION), SEDATIVE-HYPNOTICS (INCLUDING BARBITURATES), TRICYCLIC ANTIDEPRESSANTS AND OTHER

CNS DEPRESSANTS (INCLUDING ALCDHOL), RESPIRATORY DEPRESSION, HYPOTENSION, AND PROFOUND SEDATION OR COMA MAY RESULT.

Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of meperidine and its capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. In such patients, meperidine must be used with extreme caution and only if its use is deemed essential.

Intravenous Use. If necessary, meperidine may be given intravenously, but the injection should be given very slowly, preferably in the form of a diluted solution. Rapid intravenous injection of narcotic analgesics, including meperidine, increases the incidence of adverse reactions, severe respiratory depression, apnea, hypotension, peripheral circulatory collapse, and cardiac arrest have occurred. Meperidine should not be administered intravenously unless a narcotic antagonist and the facilities for assisted or controlled respiration are immediately available. When meperidine is given parenterally, especially intravenously, the patient should be lying down.

Asthma and Other Respiratory Conditions. Meperidine should be used with extreme caution in patients having an acute asthmatic attack, patients with chronic obstructive pulmonary disease or cor pulmonale, patients having a substantially decreased respiratory reserve, and patients with preexisting respiratory depression, hypoxia, or hypercapnia. In such patients, even usual therapeutic doses of narcotics may decrease respiratory drive while simultaneously increasing airway resistance to the point of apnea.

Hypotensive Effect. The administration of meperidine may result in severe hypotension in the postoperative patient or any individual whose ability to maintain blood pressure has been compromised by a depleted blood volume or the administration of drugs such as the phenothiazines or certain anesthetics.

Usage in Ambulatory Patients. Meperidine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient should be cautioned accordingly.

Meperidine, like other narcotics, may produce orthostatic hypotension in ambulatory patients.

Usage in Pregnancy and Lactation. Meperidine should not be used in pregnant women prior to the labor period, unless in the judgment of the physician the potential benefits outweigh the possible hazards, because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development.

When used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce depression of respiration and psychophysiological functions in the newborn. Resuscitation may be required (see section on OVERDOSAGE).

Meperidine appears in the milk of nursing mothers receiving the drug.

PRECAUTIONS

As with all intramuscular preparations DEMEROL intramuscular injection should be injected well within the body of a large muscle.

Supraventricular Tachycardias. Meperidine should be used with caution in patients with atrial flutter and other supraventricular tachycardias because of a possible vagolytic action which may produce a significant increase in the ventricular response rate.

Convulsions. Meperidine may aggravate preexisting convulsions in patients with convulsive disorders. If dosage is escalated substantially above recommended levels because of tolerance development, convulsions may occur in individuals without a history of convulsive disorders.

Acute Abdominal Conditions. The administration of meperidine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients. Meperidine should be given with caution and the initial dose should be reduced in certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS

The major hazards of meperidine, as with other narcotic analgesics, are respiratory depression and, to a lesser degree, circulatory depression, respiratory arrest, shock, and cardiac arrest have occurred.

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea, vomiting, and sweating. These effects seem to be more prominent in ambulatory patients and in those who are not experiencing severe pain. In such individuals, lower doses are advisable. Some adverse reactions in ambulatory patients may be alleviated if the patient lies down.

Other adverse reactions include:

Nervous System: Euphoria, dysphoria, weakness, headache, agitation, tremor, uncoordinated muscle movements, severe convulsions, transient hallucinations and disorientation, visual disturbances. Inadvertent injection about a nerve trunk may result in sensory-motor paralysis which is usually, though not always, transitory.

Gastrointestinal: Dry mouth, constipation, biliary tract spasm.

Cardiovascular: Flushing of the face, tachycardia, bradycardia, palpitation, hypotension (see Warnings), syncope, phlebitis following intravenous injection.

Genitourinary: Urinary retention.

Allergic: Pruritus, urticaria, other skin rashes, wheal and flare over the vein with intravenous injection.

Other: Pain at injection site; local tissue irritation and induration following subcutaneous injection, particularly when repeated. Antidiuretic effect.

DOSE AND ADMINISTRATION

For Relief of Pain

Dosage should be adjusted according to the severity of the pain and the response of the patient. While subcutaneous administration is suitable for occasional use, intramuscular administration is preferred when repeated doses are required. If intravenous administration is required, dosage should be decreased and the injection made

very slowly, preferably utilizing a diluted solution. Meperidine is less effective orally than on parenteral administration. The dose of DEMEROL should be proportionately reduced (usually by 25 to 50 percent) when administered concomitantly with phenothiazines and many other tranquilizers since they potentiate the action of DEMEROL.

Adults. The usual dosage is 50 mg to 150 mg intramuscularly, subcutaneously, or orally, every 3 or 4 hours as necessary.

Children. The usual dosage is 0.5 mg/lb to 0.8 mg/lb intramuscularly subcutaneously, or orally up to the adult dose, every 3 or 4 hours as necessary.

Each dose of the syrup should be taken in one-half glass of water, since if taken undiluted, it may exert a slight topical anesthetic effect on mucous membranes.

For Preoperative Medication

Adults. The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously, 30 to 90 minutes before the beginning of anesthesia.

Children. The usual dosage is 0.5 mg/lb to 1 mg/lb intramuscularly or subcutaneously up to the adult dose, 30 to 90 minutes before the beginning of anesthesia.

For Support of Anesthesia

Repeated slow intravenous injections of fractional doses (eg, 10 mg mL) or continuous intravenous infusion of a more dilute solution (eg, 1 mg mL) should be used. The dose should be titrated to the needs of the patient and will depend on the premedication and type of anesthesia being employed, the characteristics of the particular patient, and the nature and duration of the operative procedure.

For Obstetrical Analgesia

The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously when pain becomes regular, and may be repeated at 1- to 3-hour intervals.

OVERDOSAGE

Symptoms. Serious overdosage with meperidine is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

Treatment. Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonist, naloxone hydrochloride, is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including meperidine. Therefore, an appropriate dose of this antagonist should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

In cases of overdosage with DEMEROL tablets, the stomach should be evacuated by emesis or gastric lavage.

NDTE: In an individual physically dependent on narcotics, the administration of the usual dose of a narcotic antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of narcotic antagonists in such individuals should be avoided if possible. If a narcotic antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care and only one-fifth to one-tenth the usual initial dose administered.

HOW SUPPLIED

For Parenteral Use

Detecto-Seal[®] — Carpuject[®] Sterile Cartridge-Needle Unit — 2.5 percent (25 mg per 1 mL) NDC 0024-0324-02, 5 percent (50 mg per 1 mL) NDC 0024-0325-02, 7.5 percent (75 mg per 1 mL) NDC 0024-0326-02, and 10 percent (100 mg per 1 mL) NDC 0024-0328-02 all in boxes of 10.

Each cartridge is only partially filled based upon product volume to permit mixture with other sterile materials in accordance with the best judgment of the physician.

Uni-Amp[®] — 5 percent solution: ampuls of 0.5 mL (25 mg) NDC 0024-0361-04, 1 mL (50 mg) NDC 0024-0362-04, 1½ mL (75 mg) NDC 0024-0363-04, and 2 mL (100 mg) NDC 0024-0364-04 all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) NDC 0024-0365-04 in boxes of 25.

Uni-Nest[®] — 5 percent solution: ampuls of 0.5 mL (25 mg) NDC 0024-0371-04, 1 mL (50 mg) NDC 0024-0372-04, 1½ mL (75 mg) NDC 0024-0373-04, and 2 mL (100 mg) NDC 0024-0374-04 all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) NDC 0024-0375-04 in boxes of 25.

Vials — 5 percent multiple-dose vials of 30 mL NDC 0024-0329-01, and 10 percent multiple-dose vials of 20 mL NDC 0024-0331-01 all in boxes of 1.

Note: The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid. Multiple-dose vials contain metacresol 0.1 percent as preservative. No preservatives are added to the ampuls or CARPUJECT Sterile Cartridge-Needle Unit.

For Oral Use

Tablets of 50 mg, bottles of 100 (NDC 0024-0335-04) and 500 (NDC 0024-0335-06); Hospital Blister Pak of 25 (NDC 0024-0335-02); 100 mg, bottles of 100 (NDC 0024-0337-04) and 500 (NDC 0024-0337-06); Hospital Blister Pak of 25 (NDC 0024-0337-02).

Syrup, nonalcoholic, banana-flavored 50 mg per 5 mL teaspoon, bottles of 16 fl oz (NDC 0024-0332-06).

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DW-55H

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PHARMACEUTICALS

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Burt Taylor, M.D.
President, MASA

Despite All, Medicine Is Blessed

The American Thanksgiving is rooted in a distant, agrarian time when the land's autumnal bounty, inadequate though it might have been for the long, hard winter ahead, was riches enough. Life in Plymouth in 1621 was perilously close to the edge.

In the 368 years since then, the material well-being of Americans has advanced by so many orders of magnitude it is difficult for us to relate to what the harvest season meant in their lives. And yet most of us are ourselves just a few generations removed from the soil and thus bound by our heritage to these beginnings, which shaped the American character.

Accordingly, we still feel a vestigial imperative to express gratitude at this time of the year for our good fortune.

Thanksgiving has always been, ever since 1621, a time of oddly paired opposites: gratitude for the present blessings, yes; but also apprehension for the future. Surely that ambivalence was present at that first Thanksgiving almost four centuries ago. And it must have held sway in the Massachusetts Bay Colony when it inaugurated its first Thanksgiving nine years later.

The mingling of gratitude and anxiety was unquestionably hanging heavily in the air when the Continental Congress designated one or more days of Thanksgiving for every year of the Revolutionary War (1775-83) except for 1777. In none of those years could the leaders have had any assurance that they would not be hanged before the next Thanksgiving.

In the relative ease and abundance most Americans enjoy in 1989, after one of the most sustained periods of peace and prosperity in our history, there is simply

no way we can really identify with their experience. But anyone who is not awestruck by their enduring examples of stoic sacrifice and unbending fortitude is poor indeed — poor in spirit, the most intractable poverty of all.

At times while serving as your President, I feel the challenges we face, taken in the mass, are close to overwhelming. Then I am reminded of the long line of physicians who served the profession and this country even before Benjamin Rush, M.D., signed the Declaration of Independence. I am reminded of the succession of Association physicians who served you and me since before the Civil War, and of the daunting challenges they faced in their time — horrendous epidemics with few countermeasures available to them; no public sanitation; widespread ignorance of basic health and hygiene, coupled with political hostility toward the very idea of an "elitist" professional class and its undemocratic notions.

I think of the physician-merchants and physician-farmers in the late Dr. Holley's *History of Medicine in Alabama* who were thus hyphenated because they could not subsist on practice alone.

Whatever our circumstances in these, the last days of the 1980s, and the last decade of this century, we are so incomparably blessed that a recitation of our woes, in this season of our discontent, seems to trivialize the long and painful march of medicine down the centuries.

We may bemoan the slings and arrows of government and other third-party payers, taking deep offense at the new management types who seem to know the

price of everything but the value of nothing. But if the MASA President of, say, 1889, or even 1939, were to materialize before me and demand a status report of the legacy his generation left, what could I possibly dare to list as a hardship, knowing something of what he had been through?

Anything I might say of our present travail would be met with such guffaws of derision that I would be reduced to the silence of utter humiliation.

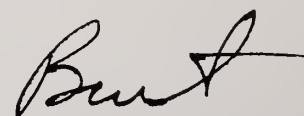
All physicians alive to read these words are incomparably blessed, as are their patients, in the incredible weapons of healing handed down to us by preceding generations; incomparably blessed in the countless daily miracles we confer on American patients.

Physicians are also blessed by material rewards beyond the wildest dreams of our professional predecessors. Some Alabama doctors still living can remember how it was as late as the Great Depression of the 1930s, when a house call that lasted all night might be remunerated with a hearty breakfast, or a ham in barter, or nothing at all.

So all of us now practicing, taking one thing with another, are immeasurably better off than any physicians have ever been in the history of the profession. And the greatest of all the compensations of our science and art is serving humanity. All else pales in comparison with this reward, the principal one we sought when we signed on for the long journey. The philosopher was right: "The reward of a thing well done is to have done it."

Even if the present clouds over our profession are not to disperse, I believe that 20 years hence we can look back on the 1980s, which end in a few weeks, and say (as Dickens did of the French Revolution):

"It was the best of times, it was the worst of times; it was the age of wisdom, it was the age of foolishness. . . . It was the season of light, it was the season of darkness. It was the spring of hope, it was the winter of despair."



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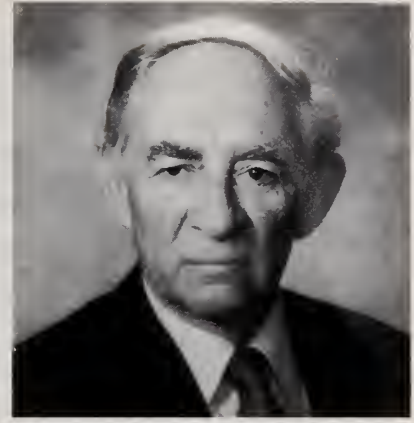
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Claude L. Brown, M.D.

Another House Call

Part I

They lived a mile and a half from the post office, and no one ever saw Old Martha. There were lots of tales — almost legends, because Tom and Martha, his sister, had lived there so long, and were such dimly seen (she, invisible) creatures. If anybody mentioned her, it was just “that crazy woman who lived in the swamp.” None of us kids had ever seen her. Once I asked Dad, “Is old Martha Roundtree really a witch?”

He had been sorting through his doctor’s bag; his quick-moving fingers stopped. “The ideas you come up with, Jed — The Roundtrees are odd, all right — but I don’t think she’s a witch.”

“Dad, can I go with you sometime when you make a call on old Tom and Martha?” I knew that he was the only person in town who ever visited them. If he took me I’d be the only kid who’d ever seen their place, and Martha.

He looked carefully at me. “Maybe, sometime — but don’t you be wandering down there, on your own. Those old folks are funny.” So he hadn’t said yes or no, and he hadn’t said positively that Martha wasn’t a witch.

One morning old Tom came into Mr. Sloan’s grocery, where I had a summer job as general flunkey. Tom was tall and thin; he walked with long strides. The little paper tab on the end of the draw string of his bag of smoking tobacco dangled from one pocket of his blue shirt. Beneath the low-pulled brim of a dusty black hat was a heavy growth of white whiskers — the whiskers, a prominent nose, and his constantly moving eyes were all that I could make out of his face.

His eyes never stopped their searching; they seemed to shine beneath the black hat. They flicked over the ceiling, swept the shelves, examined the floor, and

then started all over again. His trouser-legs ended in tatters that dragged on the floor. Big-knuckled fingers scratched his beard, scratched his thigh, and occasionally touched the haft of a sheath knife that he carried in his belt.

“Morning, Tom,” said Mr. Sloan. “I guess you’ve got your check.” Everyone knew that Tom made a monthly pilgrimage into town, first going to the post office where he got his Spanish-American War check, and then going to Sloan’s where he cashed the check and bought a few groceries. He didn’t have to spend all his money because the Baptist congregation gave Mr. Sloan donations for the Roundtrees.

Tom said nothing, just handed the check to Mr. Sloan, who rang open the cash register and counted out bills that he gave to Tom. Holding the money in his hand Tom wandered around the store. “Got any ham?” he asked.

He drifted around, his eyes never still. His glance stopped on me. “You be Doc Martin’s boy?”

“Yes, sir —”

“Your ears set on your head like his do. Your pa — he wasn’t at San Juan Hill, was he? Deserted, did he?”

“No — no, sir, he wasn’t in that war — he wasn’t old —”

He grumbled, “We needed doctors — lots of flux among the men — I got it, nearly died — I didn’t see him around anywhere.”

Mr. Sloan had been gathering up groceries; he said, “I believe it’s all here, Tom — what else you want? Candy, maybe? Gum drops?”

Tom grabbed the proffered bag of candy. He plucked out a gum drop and handed it to me. “Here, boy —

your pa is a good fellow — he waits on Martha and me when we're sick. You like squirrels?"

"Yes, sir — I had a flying squirrel once, and —"

"Too little to eat — nothing but skin and a tail — I mean big grays. Some day if you're up Panther Creek, a ways in from the road, holler for me real loud. I'll show you how to trap a squirrel."

His nose twitched; his eyes danced over the store; his fingers touched the handle of the knife. He picked up the basket of groceries and stalked out.

Mr. Sloan grinned at me. "He could probably show you how to trap things, all right — they say he's got Indian blood in him — I wouldn't go monkeying around in the swamp with him, though — he might take you for one them Spaniards, down in Cuba, and scalp you. You saw that knife, didn't you?"

I sure had, and seeing it made old Tom that much more fascinating.

After Sunday dinner the next day I took my fishing pole and was going across the back yard when Mother called, "Don't you go too far — it looks like rain."

I cut through our field to Jackson's Lane. Panther Creek, ran under a wooden bridge on Jackson Lane, one-half mile from Main Street. About two hundred yards from the bridge was a big pool where the stream widened and deepened; I had caught two perch there a week ago. Beyond the pool the creek narrowed and flowed another half-mile or so into the swamp. We rarely ventured much further than the pool, because the swamp became dense and the walking got mucky. There was a dim trail that skirted the stream, and somewhere down that trail, a good ways into the swamp, lived old Tom and Martha. That was another reason why we didn't go much past the pool.

I walked down the sandy lane almost to the bridge. Just as I passed a big magnolia tree a fellow who had been hiding behind the tree suddenly lurched out. Startled, I impulsively swung my pole at him. Even as I jerked the pole around I recognized Ezra Jackson, so I didn't actually hit him. He stumbled a few steps forwards, blinking his eyes, and muttered, "Don't you hit me — I'll snatch that pole and tan you good with it."

Jackson's Lane had been named for Ezra's father. Mr. Jackson had been one of the first settlers of the town. He had built a big house at the end of the lane, a couple of miles from Main Street. He had farmed, prospered, and had been well thought of, but he hadn't had much luck raising Ezra. And then the parents died, and Ezra continued to be the town drunk. He wouldn't work, just gradually sold off most of the property. He still lived in the old house, but it was a wreck. He kept a few pigs, and a wife whom he beat.

Ezra stopped, his burly figure weaving. "Aw — you're Doc's kid — I thought you was one of them others" — he waved vaguely down the lane; he meant

one of the kids from the few shanties that clustered at a bend of the road.

"You ain't got a dime you can loan me, eh? Loan me one — don't tell your Dad, though — ain't you got a dime — maybe a nickel?"

I said, "Go on, Ezra — I haven't any money — I'm just going fishing." I didn't think he'd bother me. But once I had seen him break a dog's leg with a pitched rock.

He growled something that I couldn't understand as he stumbled over to the tree and leaned against it. I walked pretty fast, over the bridge, and then down to the bank of the creek. I looked back; he was still staring. He seemed to be looking past me, though — looking at the trail, as it wound off into the bush along the creek.

I fished along the north side of the pool for fifteen, twenty minutes. It wasn't a good time of day to be fishing, and there were no bites. Still worrying about Ezra back there in the lane, I decided to move a ways down the creek. I threaded my way along, ducking under branches and occasionally stepping on ground that looked solid but was squashy when my weight came on it. The undergrowth was dense. Taller trees, mostly oak and gum cast heavy shade. It was quiet like it usually is in a swamp.

The twisting path quickly took me out of sight of the pool. I had never gone so far into the swamp, and not knowing how much farther it was to the Round-tree's place I figured I'd just drop my line into the creek here and not explore any more. I floundered through some weeds, found a dry spot on the edge of the creek, and sat down. The sun was gone, grey clouds were piling up, and the sweat dripped off me in the muggy heat.

A voice behind me made me almost jump into the creek. I had heard nothing: no rustling of grass or branches, no twigs cracking. Just out of nowhere, a voice right behind my shoulder said, "No fish there, boy."

Old Tom stood a yard away, looking like a natural part of the swamp. He seemed to blend into the background — all except his eyes, which glistened as they kept up their restless movement.

He deftly rolled a cigarette and stuck it in a corner of his mouth. All the while his eyes were jumping in every direction. He said, "Maybe a few fish in the pool — trapping is surer, though, if you're hungry."

I said, "Yes sir — I don't have any traps —"

"Don't need to *have* any — make 'em yourself." He scratched a match with his thumbnail and held the flame to the twisted end of the cigarette. "Come on — I'll show you."

He went through the brush to the trail without making any sound, although he didn't seem to be moving with particular care. His loping gait was faster than

mine; we went another quarter-mile and then he dived into the undergrowth again. Somewhere off in the brooding swamp a squirrel *chirred* quietly. Tom held up his hand and I stopped.

"First you find where they're coming out of the trees, going to feed or water — then you make a trap and set it there."

He sat down on the ground and from a pocket pulled a small coil of wire. I squatted beside him; this was good stuff. I was so interested that I forgot my uneasiness, forgot that I was down in the swamp where I wasn't supposed to be, forgot about Ezra startling me.

Tom seemed absorbed: His bony fingers twisted the wire into a loop, he then tied a string on this, and he had just pulled his knife from his belt when he stopped stock-still. With the knife blade motionless in one hand, the string and wire in the other, he quickly turned just his head. He reminded me of an owl, the way he turned his head so far in one direction, and then rapidly turned it back the other way so far that I could almost think that he had completely rotated his head on his neck. He sniffed several times and his eyes snapped. I jumped to my feet.

Tom didn't look at me, but hissed, "Shu-u-sh." My heart was hammering violently; sweat trickled over my ribs and my mouth was cottony. What the heck was he looking and listening for?

Finally he whispered, "Did you hear it?"

"What?"

"Seemed like a low humming sound — more like drums — yeah, drums — like when you hear them a long way off, over a hill."

I stammered, "I didn't hear anything — maybe it was thunder." The sky had steadily darkened; the swamp was gloomier in the fading light.

Tom whispered, "No thunder, boy — maybe rifle fire, if they're attacking somewhere along the line." The knife twitched in his hand. He slowly stood erect, wary.

I was ready to run, but I didn't know if I could move. I said, "I better get home — it's going to rain — I'd like to see that trap when you finish it, some day."

Tom, motionless, still listening, head half-cocked, said in a low voice, "— ain't never going to finish this snare, boy. Something's after me — I hear it, and I smell it, and every now and then I can glimpse it, away off in the shadows." A cool wind, signalling the coming rainstorm, soughed through the trees.

I went down the trail as fast as I could go without actually running. I didn't dare look back. The way Tom could move soundlessly made me shiver, thinking maybe he was just behind me, ready to scalp me. I finally passed the pool, and then the bridge and the lane came into sight. Ezra Jackson wasn't around. I

got home just as the first drop of rain fell; I was already as wet as if I had been in a downpour.

Dad and Mother and I had almost finished breakfast the next morning when a panting black man ran up our back steps and knocked loudly.

Dad grimaced, "Looks like the house calls are starting early today." He walked out on the steps, talked briefly with the man, and then hurried back into the house.

Mother asked, "What's the matter — some poor soul sick?"

Dad grabbed his bag and coat and started out again, saying to her over his shoulder, "Pete says he was coming up Jackson Lane and when he crossed the bridge over Panther Creek he looked down the trail into the swamp and saw a body lying there." Dad was getting into his car when I caught up to him.

"Dad," I asked urgently, "let me go with you."

"I'm in a hurry, Jed — this won't be any place for you —"

(To be continued)



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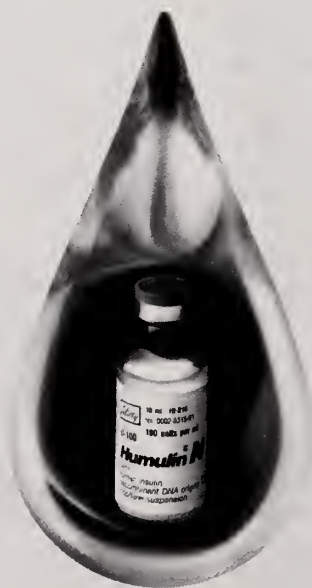
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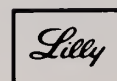


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Patient-Controlled Analgesia in Gynecologic Oncology Surgery

Kenneth C. Brewington, M.D.*

Abstract

A prospective comparison of conventional analgesia and patient-controlled analgesia using morphine was conducted. Each patient underwent a major gynecologic oncology procedure and was observed on the post-operative floor. All 192 patients were studied during the first three post-operative days. The findings suggest less total medication and less sedation with equal pain control in the patient-controlled analgesia group.

Introduction

This study is a prospective analysis of post-operative analgesic methods. The methods compared are intramuscular prn (pro re nata) and patient-controlled analgesia (PCA) and the primary medication is morphine sulfate. The patients studied are those undergoing major gynecologic oncology procedures in my practice.

The fear of post-operative pain remains one of the major concerns of most patients facing surgery. When combined with the known fear of pain experienced by cancer patients¹ the anxiety of the patient before a major oncologic surgical procedure is magnified. Assurance by the surgeon and nursing staff of adequate pain control in the post-operative period is most effective when both understand and believe in the efficacy of the analgesic method.

For over 20 years the method of patient-administered analgesics using small doses has been discussed,² but only recently has it been readily available. Several

products are now commercially available which allow controlled administration of analgesics with or without a baseline steady dose. Each product has differing specifications and it is not the purpose of this paper to evaluate them.

The findings suggest that PCA is an effective method of post-operative pain control in the population studied and is well-accepted by those patients.

Materials and Methods

Patients selected for this study were all gynecologic oncology patients requiring a major surgical procedure as part of cancer therapy or to treat complications of prior therapy. Those strictly excluded are listed in Table 1.

The selection for conventional analgesia (CA) with prn intramuscular dosing or PCA with morphine was made on an alternating basis without subjective bias. All patients were instructed in pain control methods preoperatively and introduced also to the scale for pain intensity score (Fig. 1). The scale was 10 centimeters in length and could be then numerically scored daily.

In the recovery room all analgesics were given as bolus intravenous medications by the anesthesiologist. The analgesic study began as the patient was transferred out of the recovery room to her room on the

TABLE I
Patients excluded from study:

- | |
|---|
| <ol style="list-style-type: none">1. Known allergy to morphine.2. History of drug or substance abuse.3. Inability to adequately participate because of physical or emotional limitations. |
|---|

* Clinical Assistant Professor, University South Alabama

Figure 1. Pain Intensity Scale.

None _____ Most Severe

Please note on the line that best represents your pain.

oncology floor. Those requiring intensive care unit transfer were eliminated from the study (Table 2).

The conventional analgesia patients had morphine sulfate prescribed at eight to 12 milligrams IM every three to four hours as needed for pain. The PCA patients had morphine sulfate loaded in the syringe with settings to allow a one milligram dose and a lockout period of 12 minutes. An initial loading bolus of three to five milligrams was given when the system was initiated. Bolus doses of three milligrams by the nursing personnel were allowed each hour if needed. Each patient was evaluated for three days.

Information was compiled on the effectiveness of pain relief by asking the patients to identify their worst pain over the preceding 24 hours on the pain scale. Total drug dose per day was recorded. Sedation was subjectively monitored by the nursing personnel every two hours (Table 3). Nausea and vomiting thought to be related to medication was noted and the patient then was changed to another analgesic and eliminated from the study (Table 2).

Patients that had previously undergone laparotomy using CA and used PCA in this study were asked to select which method they preferred.

Statistical analysis was performed using the students' t test and significance was assigned for $p < 0.05$.

Results

A total of 224 patients were entered into the study in the recovery room. Thirty-two patients were withdrawn from the study for the reasons noted in Table 2. In Table 4 the general categories of surgical procedures are listed. The laparotomies were for ovarian cancer cytoreduction, surgical re-evaluation, bowel obstructions, etc.

The averages of the pain intensity scores is shown in Table 5 and analysis shows no significant difference

TABLE 2
Patient Population

	CA	PCA
Entered in RR	112	112
Removal from study	17	15
To ICU	9	7
Side-effects (nausea, etc)	8	6
Inadequate relief	0	2
Patients evaluated	95	97

TABLE 3
Sedation Score

1 — Alert
2 — Drowsy
3 — Dozing
4 — Sleeping
5 — Unarousable

TABLE 4
Surgical Procedures

	CA	PCA
Hysterectomies	51	61
Laparotomies	37	28
Extensive vulvar surgery	4	6
Exenterations	3	2
Totals	95	97

TABLE 5
Pain Intensity Scores

	CA		PCA	
	Avg.	Range	Avg.	Range
Day 1	5.2	3.1-7.7	4.4	3.0-8.0
Day 2	3.3	1.5-6.1	3.1	1.4-5.8
Day 3	1.7	0.9-3.1	1.5	0.5-3.0

between the two groups. Table 6 shows the total doses of analgesics given and the difference between the two groups is significant ($p < 0.05$).

Sedation scoring was calculated as a daily average (Table 7) and there was a significant difference ($p < 0.05$) each day. All 52 patients who had previously had laparotomies using CA preferred the PCA method of pain management.

Discussion

To eliminate bias in patient selection the recovery room nursing supervisor assigned the analgesic method in an alternating fashion. Since it is difficult for the immediate post-operative patient to use the PCA method,³ intravenous analgesics were administered by the nursing personnel in the recovery room under direction of the anesthesiologists.⁴

The pain intensity scale (Fig. 1) was used to obtain an objective measurement for comparison.³ The difference between the two groups is not statistically significant in this study. Studies by Albert⁵ and Ferrante⁴ found no differences in the perceived pain by their patients. The study of gynecologic patients by Dahl³

TABLE 6
Total Dose of Morphine Delivered (mg.)

	CA		PCA	
	Avg.	Range	Avg.	Range
Day 1	26	16-42	18	7-40
Day 2	19	8-36	13	3-39
Day 3	5	0-20	5	2-15
Totals	50	32-74	36	18-62

also failed to identify any difference in perceived pain intensity between the two methods.

The average total doses of analgesics administered over the 72-hour period showed a statistically significant difference between the two methods. When viewed with the apparent equality of pain intensity there seems to be a more efficient use of morphine with the PCA method. Many authors^{5, 6, 7, 8} note a significant reduction in analgesics required with the PCA method. Dahl³ fails to identify this reduction in total dosage, but his entire study was done in a recovery room setting with increased nurse-patient ratios. In that setting the patient is assured of a much quicker response to analgesic requests and the anxiety which can alter the perceived pain level is reduced.

Level of sedation was a subjective recording; all patients were maintained on the oncology floors and there was consistency of personnel throughout the study. The significant difference shown between the two methods regarding sedation supports previous studies.^{5, 9} Reduced sedation with adequate pain control allows earlier and more frequent ambulation^{5, 8} and an improved sense of well-being by the patient.⁷

An additional finding in this study was that patients exposed to both analgesic methods preferred the PCA method unanimously. Ferrante⁴ notes patient preference for PCA despite his objective measures which show the methods to be equal. In a study by White,¹⁰ 71 percent of patients report no significant discomfort during the period of study on PCA.

A study by Lange⁷ suggests there is more time available for nurses to care for patients when less time is spent in drug preparation and administration. Jackson⁸ shows significant cost savings based on nursing time, medication costs, and length of hospital stays. These

TABLE 7
Sedation Scoring

	CA		PCA	
	Avg.	Range	Avg.	Range
Day 1	3.6	2-5	2.1	2-4
Day 2	3.0	2-4	1.5	1-3
Day 3	1.9	1-3	1.1	1-2

parameters were not a part of this study but do suggest further advantages of the PCA method.

Conclusion

Adequate analgesia remains a paramount concern among surgical patients. The fear of pain in many of these patients has even caused delays in their seeking care. With PCA there is a method which can provide good pain relief with reduced sedation and superb patient acceptance. Less analgesic is required with equal pain control to the CA method. Several different infusers are available which can provide safe and effective administration.

As physicians and nurses become more familiar with this method many will prefer it. As patients become exposed to this option many will request it. Further studies with detailed cost-accounting will be required to determine the cost-effectiveness. Varied analgesic agents will need to be evaluated to determine the optimal choices. ■

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Lymphadenitis Due to Atypical Mycobacteria

Michael C. Lindberg, M.D.*

George G. Thomas, M.D.†

Abstract

Mycobacterium scrofulaceum is a Group II atypical mycobacterium commonly associated with lymphadenitis in children. An adult is described with a rapidly enlarging preauricular mass. Culture of biopsied material isolated *M. scrofulaceum*, a rare cause of disease in nonimmunocompromised adults. *M. scrofulaceum* is usually resistant to multiple chemotherapeutic agents used for the treatment of tuberculosis. Treatment is by surgical excision of the nodes and overlying skin.

Introduction

The differential diagnosis of an expanding neck mass¹ in adults includes pyogenic nodes, tubercular nodes, cat-scratch disease, infectious mononucleosis, mumps, abscess, impacted salivary duct stone, and primary or metastatic tumor. The differential can be narrowed by careful history taking and examination. Pyogenic nodes are often tender, hot, edematous and associated with systemic symptoms such as fever. Cat-scratch disease² is usually associated with exposure to a cat and the development of a pustule at the site of inoculation. Tuberculous lymph nodes in adults³ often present in combination with other symptoms of tuberculosis, a prior exposure history, a positive chest radiograph, or a positive purified protein derivative skin test.

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When the diagnosis is not obvious from the history and physical examination, a tissue biopsy is often necessary. In adults, where mycobacterial infection is suspected as the cause of the mass, *M. tuberculosis* is the most common etiologic organism.^{4,5} The atypical mycobacteria, as originally classified by Timpe and Runyon,⁶ or as now sometimes referred to as mycobacteria other than tuberculosis,⁷ are more often seen in children.⁸⁻¹⁰ This case describes the unusual isolation of an atypical mycobacterium from an expanding preauricular mass in an adult.

Report of the Case

The patient is a 58-year-old black male who presents with the complaint of an enlarging, painful mass of the left preauricular area. At the time of his initial exam, a needle aspirate of the mass was obtained and sent only for routine culture. A PPD was placed and remained negative at forty-eight hours. The patient was started on oral erythromycin. He returned in forty-eight hours and saw a second physician because of lack of response to antibiotic therapy. At that time, a 4.5 × 4.0 cm fluctuant, mildly tender mass, with draining sinus tracts, was noted in the left preauricular area, extending down to the angle of the jaw. No cervical, supraclavicular, axillary, or inguinal nodes were appreciated. There was no evidence on examination or history of conjunctivitis or trauma to the eye or facial tissues. The remainder of his examination was within normal limits. He noted drinking several six-packs of beer weekly, smoked one pack of cigarettes a day for forty years, and denied drug use and homosexual encounters. He denied fevers, chills, night sweats, anorexia, weight loss and other constitutional symptoms with the exception of a mild upper respiratory tract

infection one week prior to presentation. He denied any foreign travel.

He reported first having a "boil" in the same area approximately ten years earlier which was treated by incision and drainage by a physician in another state. A review of his clinic records showed he presented with a 1.0 × 1.0 cm preauricular node in 3/82 which was treated with erythromycin. He did not return for follow-up. He presented next in 8/83 with a similar complaint and was treated with erythromycin plus ampicillin. Again, the patient did not return for follow-up.

The skin over the fluctuant area was incised and 80 cc of caseous material was excised. The cavity was irrigated and a drain was left in place. A gram stain of the excised material showed no organisms. A routine culture of the needle aspirate and the surgically obtained specimens showed no growth. A stain for acid fast bacilli also showed no organisms. Four weeks later, the culture for acid fast bacilli was positive and the organism was subsequently identified as *M. scrofulaceum*.

Discussion

Mycobacterial cervical lymphadenitis, or "Scrofula," is a long recorded disease classically caused by *M. bovis* until the pasteurization of milk became common. In the United States, causative organisms now include *M. tuberculosis* and the atypical mycobacteria. Because of the control of mycobacterial infections in cows and milk products, this disease is less frequent. It is still seen in rural areas of the United States, and in immigrants from areas of Europe and Asia where the disease remains endemic.¹¹ In a review of twelve patients with tuberculous lymphadenitis,¹² eleven patients were immigrants to the United States. Ten of these had been in the United States for less than five years. Eight were from Southeast Asia and three from Latin America. Studies in Britain suggest that the majority of cases of tuberculous lymphadenitis present in immigrants from the subcontinent of India.¹³

The presenting complaint in patients with mycobacterial lymphadenitis is most commonly an enlarging mass, ranging from 60% (47% painless enlargement, 13% painful enlargement)³ to 98%.⁵ Other common presenting signs and symptoms^{3, 5, 11} include weight loss (18-20%), fever (10-15%), anorexia (8%), fatigue (6%), productive cough (4-5%), and a draining sinus tract (2-10%). The most valuable tests for making the diagnosis of mycobacterial lymphadenitis include the purified protein derivative skin test and biopsy of the mass with appropriate stains and culture.⁵ If available, purified protein derivative subtypes may be of benefit in differentiating the type of mycobacterium causing the lymphadenitis.⁸ In children from whom *M. tuberculosis* was isolated by culture, the response to PPD-S was the same, or larger, than their response to

PPD-B (Batty antigen) or PPD-G (Guaze antigen). However, in those patients found by culture to have an atypical mycobacterium, there was no response to PPD-S despite a response to PPD-G and/or PPD-B.

The most common location for mycobacterial infected lymph nodes^{3, 14, 15} is the neck, usually involving the anterior cervical chain, followed by the posterior cervical chain, supraclavicular nodes, and submandibular nodes.¹⁶ Other sites of involvement include axillary, abdominal, groin, mediastinum, and preauricular nodes. A review of this histopathology¹⁷ of lymphadenitis caused by mycobacterial infections showed it to be impossible to differentiate *M. tuberculosis* from atypical mycobacterial lymphadenitis or cat-scratch disease based on histology alone due to the variety of patterns seen on exam.

Mycobacterial lymphadenitis, when seen in the adult, is generally caused by *M. tuberculosis*. A review of tuberculous lymphadenitis done in southeast England¹⁸ revealed that of 2339 patients with mycobacterial lymphadenitis, 2272 had *M. tuberculosis* and only 67 had atypical species, 56 of which were *M. avium-intracellulare*. Of the 67 patients with atypical disease, only three were over the age of sixteen. A Canadian study⁴ of cervical lymphadenitis reported that 71% of cases of *M. tuberculosis* lymphadenitis were seen in patients aged twenty to fifty, while cases of atypical cervical lymphadenitis were seen exclusively in children. Another study⁵ showed tuberculous lymphadenitis cases ranging in age from two years to seventy-three, with an average age of thirty-five.

Unlike adults, children more commonly show atypical species of mycobacteria as the cause of lymphadenitis. A review of 380 cases¹⁹ showed that three atypical species caused the majority of disease. In the Dallas area prior to 1972, 70% of cases of atypical mycobacterial lymphadenitis were due to the Group I atypical mycobacterium species *M. kansasii*. Since 1973, the Group III species, *M. avium-intracellulare* has accounted for 70% of the isolates. A review of the world literature¹⁵ concerning childhood atypical mycobacterial lymphadenitis showed that Group II mycobacteria accounted for 61% of the isolates, Group III for 32%, Group I for 6%, and Group IV species (*M. fortuitum*) for 1%.

This report describes a case of lymphadenitis due to *M. scrofulaceum*. *M. scrofulaceum* is a Group II atypical mycobacterium, a scotochromogen characterized by yellow to orange colonies when cultured in the dark. It was first described as a human pathogen in childhood lymphadenitis by Prissik and Masson in 1956.^{20, 21} *M. scrofulaceum* as a cause of adult pulmonary disease was subsequently reported.²² *M. scrofulaceum* has also been isolated from disseminated mycobacterial disease in immunocompromised adults.¹

Whether mycobacterial lymphadenitis is a primary or secondary disease remains controversial. In adults

with lymphadenitis due to *M. tuberculosis*, the disease may result from the hematogenous spread from a primary focus in the lung or gastrointestinal tract.^{3, 14} However, some investigators feel that because *M. tuberculosis* is rarely found in other organs at the time of lymph node isolation, tuberculous lymphadenitis may be considered a primary disease.²³ In children with atypical cervical lymphadenitis, the lymph nodes may be inoculated following exposure of the oropharynx to atypical mycobacteria,^{1, 9, 10} although this mode of transmission remains to be firmly documented. There is one case report¹⁵ of a three-year-old girl with a case of "pink-eye" that preceded the development of a swollen preauricular node which subsequently broke down and was followed by cervical node enlargement. Biopsy specimens were cultured and *M. scrofulaceum* was isolated.

The management of atypical mycobacterial lymphadenitis requires surgical resection of the involved nodes, whereas *M. tuberculosis* lymphadenitis may respond to chemotherapy. Surgical intervention is preferred in the atypical cases to: 1) provide a precise identification of the causative organism; 2) prevent local recurrence or the development of draining sinus tracts; 3) serve as primary therapy because atypical mycobacteria are frequently resistant to multiple chemotherapeutic agents.¹⁹ Tuberculous lymphadenitis can be treated with 18 to 24 months of chemotherapy,^{3, 25} although a recent study²⁶ has suggested that a nine month course of isoniazid plus rifampin may be adequate. If the disease fails to respond to chemotherapy, recurs, or if sinus tracts develop, surgical excision is indicated.²⁵

This case was unusual in that a preauricular lymphadenitis was caused by *M. scrofulaceum* in an adult. Few cases of atypical mycobacteria causing adult lymphadenitis have been reported. These include a submandibular lymph node in a twenty-three-year-old female²⁷ and an eighteen-year-old male with a retropharyngeal abscess.²⁸ In both cases, *M. avium-intracellulare* was isolated on culture. There is no evidence for pulmonary or disseminated illness in this patient, and his disease appears to have taken a long, indolent course. The mode of infection with *M. scrofulaceum* remains unclear. Why he experienced rapid enlargement of the infected preauricular mass is uncertain,

although he had a mild upper respiratory tract infection one week prior to presentation. Upper respiratory tract infections have been reported to precede enlargement of lymph nodes infected with atypical mycobacteria.¹⁵ The isolation of *M. scrofulaceum* from biopsied material in this patient allows for definitive treatment by surgical resection. □

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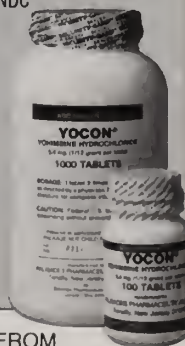
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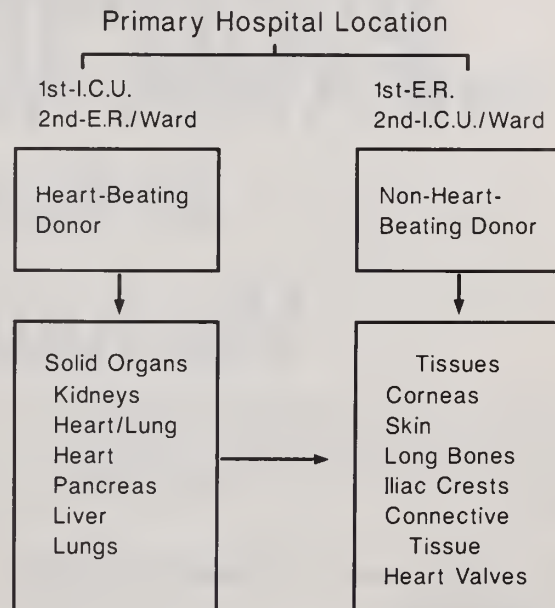
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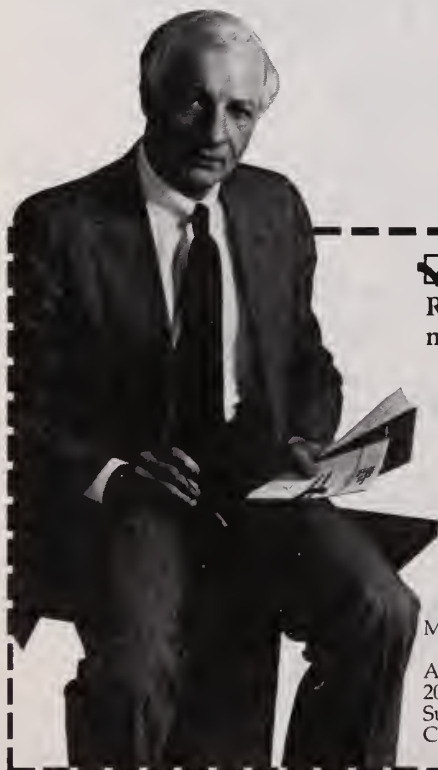
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Cholesterol and YOU — Do You “Know Your Number?”

In promoting the health and welfare of all citizens, the American Medical Association created AMA'S CAMPAIGN AGAINST CHOLESTEROL, a program designed to reduce the incidence of heart disease due to high cholesterol levels. The AMA has published a folder of facts, news releases, and “how-tos,” and has supplied many physician's offices with this information. If you would like a copy, a request to AMA is all that is necessary.

Many books are available on this subject, including one written by Art Ulene, M.D., and endorsed by AMA, entitled “Count Out Cholesterol.” The American Heart Association has two excellent cookbooks: “The American Heart Association Cookbook, Fourth Edition,” and “Low-Fat, Low-Cholesterol Cookbook” published in 1989. Numerous articles have appeared in all the leading magazines, and television has had its share of informative programs. Information and help are available to those who wish it.

One of the health emphases of the Auxiliary to the Medical Association of the State of Alabama for this year is this campaign against cholesterol which we call “Know Your Number.” At the Fall Leadership Conference and Workshop held September 12/13 at the Wynfrey Hotel in Birmingham, Anderson M. Morris, M.D., cardiologist in private practice in Birmingham, gave a very informative talk and slide presentation on cholesterol. Auxilians and our Medical Association

guests and spouses were interested in the facts presented to us by Dr. Morris.

More than half of all adult Americans have blood cholesterol levels of 200mg/dl or greater, which places them at an increased risk for coronary heart disease. Of this group, approximately 50% have values over 240mg/dl, a level that more than doubles their risk of heart attacks. The National Cholesterol Education Program (NCEP) has fixed the following guidelines for total blood cholesterol levels for adults over 20:

Less than 200mg/dl	Desirable
200-239mg/dl	Borderline-high
240mg/dl and up	High

Cholesterol isn't the only risk factor in the development of coronary heart disease. Other risk factors that need to be considered and can possibly contribute to the problem are:

- (a) family history of heart disease
- (b) high blood pressure
- (c) being a male
- (d) severe obesity
- (e) cigarette smoking
- (f) diabetes
- (g) known heart or artery disease

If you have a high cholesterol level you should have a recheck by your physician, to rule out errors of

testing or human errors. If you still have a high cholesterol level on the second test and any two of these risk factors, your physician should help you with decisions about actions to take to lower your cholesterol level. These include trying to control known health problems, changing your diet to include "heart-healthy" foods, exercise, and medication if none of the others work.

Also at the Fall Workshop, several pamphlets published by the American Heart Association (AHA) were distributed, and may be purchased from the AHA to help educate your family and your patients. The best were:

The American Heart Association Diet	\$7.80/100
Cholesterol and Your Heart	6.20/100
Eat Well, But Wisely	2.28/100
How to Have Your Cake and Eat It Too	4.80/100

I think it would be an aid to our communities if physicians had copies of these pamphlets in their offices to help our fellow Alabamians in dietary planning to try to improve the health of their hearts.

We have asked the County Medical Auxiliaries to implement this state-wide "Know Your Number" campaign against cholesterol by undertaking two of the following projects, and to report on the success of the projects undertaken to Patricia Birdsong, Cholesterol Education Chairman, A-MASA, 1200 College Hill Road, Jasper, AL 35501, or Terri Glasgow, Health Projects Chairman, A-MASA, 3009 Brookwood Road, Birmingham, AL 35223, or Martha Anne Hardiman, President, A-MASA, Rt. 8, Box 120, Florence, AL 35630, by February 15, 1990.



Auxiliary,
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1. Encourage each Auxilian and physician, as well as family members, to have a cholesterol check. **KNOW YOUR NUMBER!**
2. Plan an Auxiliary meeting on cholesterol, distributing pamphlets from the American Heart Association about diet and cholesterol.
3. Feature low cholesterol snacks at a meeting, and share recipes.
4. Donate a book/books on heart health to your public library.
5. Coordinate and/or sponsor community cholesterol screening efforts, with well-planned follow-up for persons screened that have high cholesterol levels. **THE WEEK OF NOVEMBER 12-18 IS SUGGESTED FOR THIS.**
6. Promote the use of newspaper, radio and tv public service announcements concerning cholesterol education with the Medical Society/Auxiliary credited with sponsorship.
7. Negotiate with local restaurants to prepare and highlight at least one Heart Healthy entree in consultation with the AHA.
8. Ask local school boards to have school menus meet the Dietary Guidelines for Americans developed by the Department of Health and Human Services and the U.S. Department of Agriculture.
9. Conduct Heart Healthy cooking classes for the public.
10. Prepare a Heart Healthy Recipe Book from favorite recipes of Auxiliary members.

The Auxiliary's Winter Workshop is January 23/24 in Montgomery, and we have plans to involve our State Legislature in our Cholesterol Education Project. We want them to realize that we are concerned about the health and well-being of all Alabamians, including them!

We think that any of these projects could and should be carried out by counties that do not have organized auxiliaries, because anything that we can do to improve the health of Alabamians will be great! Physicians and physicians' staffs would be a grand starting place, also. I know you have the knowledge and I hope your interest is whetted enough for you to take action! •

Martha Anne

SOMETHING TO THINK ABOUT...

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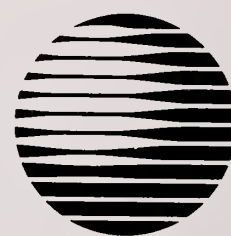


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About the Cover

Season's Greetings from the Middle Ages, when medical schools were not as crowded as they are today. This 1497 woodcut from 'Hortus Sanitatis,' published in Strassburg five years after Columbus discovered America, is considered the most important illustrated work on the natural sciences of the period. It depicts the teaching setting of that era of medicine. From the priceless collection of the late Lawrence Reynolds, M.D. (1889-1961), Lister Hill Library of the Health Sciences, Birmingham.

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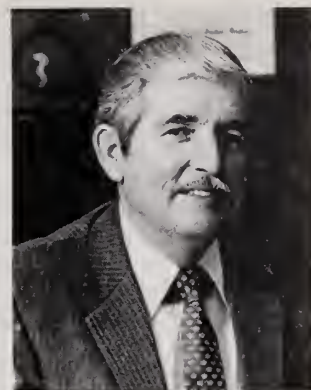
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Walking Softly

Perhaps I should not have been surprised: the reaction of Alabama physicians to the institution of MASA's Third Party Grievance Task Force has elicited an enthusiastic response from you that eclipses anything in my years with the Association.

Your officers, Board members, MASA staff — all report unprecedented approval of this major step taken by the Association. We knew it would be well received; what surprised all of us was the *level* of enthusiasm. Many physicians have had the same comment — “best thing the Association has ever done.” And a few have even added, “best thing you will ever do.”

The simple ground rules for the Task Force meetings are conducive to such speech: All discussion is off the record; all actions are on the record. This agreement frees those on both sides of the table to say exactly what they believe, in complete candor and mutual respect. Vituperative letters accomplish nothing; full and fair negotiation will usually lead to an accommodation, if one can be reached.

The atmosphere in the grievance meetings is one of reasonable men trying to solve a problem, not win an argument. To arrive at solutions, each side must fully understand the position of the other. The physicians on the committee are dedicated and forceful in their presentations; at the same time they know that those across the table are just as committed to their point of view and are similarly constrained by the times in which we live.

Both sides represent constituencies presently in a state of high dudgeon: employers desperate to check skyrocketing costs of health care; physicians outraged over how these concerns translate into limitations on their practice freedom.

Some carriers and some physicians seem to think compromise is weakness, somehow unmanly. A couple of centuries ago that great British conservative, Edmund Burke, was under attack for what was then regarded (the year was 1775) as something close to treason — conciliation with the beastly Americans. Burke defended his position thus:

“All government, — indeed every human benefit and enjoyment, every virtue and every prudent act — is founded on compromise and barter.”

But too many people in Britain rejected negotiation, making war inevitable.

There are, regrettably, similar sentiments of no-compromise on all sides of the health-care argument today. I am happy to report to you that in the meetings of the Task Force with carrier representatives such stonewalling has been rare. Both are there to negotiate solutions. Each side knows there can't be a zero-sum game — where one side loses everything and the other gains everything. Unconditional surrender on a point is neither sought nor expected on either side of the table.

In this my last column in the bitter decade of the 1980s I am happy to report that it is my considered judgment, one shared by the Blues representatives and the physicians on the grievance committee, that we seem to have found a functioning mechanism for reasonable people, in an atmosphere of reason, to reach reasonable solutions.

And that gives me the surest year-end hope for the future I have had as your Executive Director — that the 1990s just might see a few breaks in the overcast. In that confident mood, I wish you all the joys of the season and the best for the new year.





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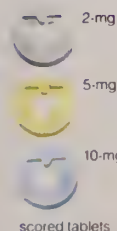
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Hopeful Signs

As we enjoy another Holiday Season in America we can realize once again that we live in a diversified, complex, wonderful country. In spite of the plight of the Middle East hostages and some persistent terrorist activities the peace initiatives throughout the world are dominating our current news.

The unexpected and unbelievable changes in Germany and Russia continue almost daily. The expressions of joy and hope by so many people should only add to our holiday season.

It has been a wonderful experience to watch the Solidarity movement under the direction of Lech Walesca continue to grow and genuinely improve opportunities for the Polish people. It was a thrill to watch a tape of Mr. Walesca's speech to a joint session of Congress. This man has put everything on the line repeatedly. He has suffered significantly. When he states, "I would like to help make Poland the America of Europe," we should all pause and reflect.

As we enter 1990 and approach the 21st Century we should remain proud of the efforts of physicians throughout the world. There have been numerous glowing reports regarding the medical communities following the natural disasters which have occurred during the past year in the U.S.S.R. and in the United States. The rapid response by the medical community in Sioux City, Iowa saved numerous lives and minimized pain and suffering. Hospital personnel responded promptly and spent countless hours giving of themselves to help those in need.

The devastation resulting from Hurricane Hugo has been well documented by the various television news reports. The medical community in South Carolina performed admirably and was "at their posts" during the storm, immediately after the storm, and for many additional weeks as the people in that state lived through their nightmare.

Only recently, the medical personnel in the San Francisco area worked with the various rescue teams and won the respect and admiration of all the world while trying to save lives, ease pain and suffering — giving and caring. That is certainly the American way and it is the way physicians perform throughout the world.

Physicians continue to work very hard and should be proud of their profession. During this continued siege on American medicine we must strive to concentrate on the positives, keep our guard up, and continue to move forward. It is indeed a very difficult time for all physicians. Our days are filled with stress, frustration, struggle, and uncertainty. But if we compare our problems with those of the various professions throughout the world maybe things really aren't that bad.

We need to be certain that the voice of American physicians can be heard over the persistent outcry of medicine's relentless detractors, such as Representative Pete Stark, Senator Ted Kennedy, and Mr. Joseph Califano, chairman of Chrysler's Health Care Committee. The physicians of America must be heard.

The media and many political leaders often speak with a significant bias. Short-sighted bureaucrats will only ensure inept planning, wastefulness, and a poor net result. We must not let them completely control the delivery of health care in America. It was only one year ago that Mr. Dukakis was proclaiming "the Massachusetts Miracle." His state is now ruined financially. There is a need to raise taxes even higher and the physicians in that state are leaving in droves. Bureaucratic overkill!

Unfortunately, big business has joined the band wagon and has decided to flail away. The Chrysler Corporation states that their health care costs are too high and they favor the "Canadian System" of health care.

Mr. Califano has been an advocate of socialized medicine for many years. Additionally, since almost all of Canada's health care funds come from general taxation, the adoption of this system would eliminate Chrysler's need to cover almost any health care costs for their employees. This would subsequently add to the costs of the average taxpayer.

At the same time General Motor's net profit this past year exceeded \$4 billion. GM also wishes to make drastic cuts in their health care provisions. Their "bottom line" is the major factor, not quality of care. It would seem to me that the automobile industry would have learned that lesson which was taught to them so beautifully in Quality of Product — Course 101 — directed by the professors from Japan and Germany during the past decade.

I am concerned that the executive branch of our government does not "hear" the average American physician. The Bush Administration's recommendations for physician payment reform were sent to Congress on Oct. 20, 1989. One of the recommendations is extremely discouraging. It contrasts with the advice and the three bills now before Congress. It essentially suggests that in "reslicing" the Medicare payment pie, the government should keep a piece for itself. Thus the emphasis would be in reducing fees for "over-valued procedures" with little or none of the savings being returned as higher payment for the "under-valued services." Additionally, it recommends that *unspecified* curbs on balance billing should accompany the fee schedule.

I think it is necessary for us to understand why this proposal would originate from the Executive Branch. There are two physicians who have offices in the White House. They certainly have the President's ear. Neither of these men have been in private practice during the past few decades or facing the problems that the average physicians of American must face each day.

President Bush's personal physician, Dr. Burton J. Lee, III, is 59 years old and has spent his entire professional career, 30 years, as a medical oncologist at the Memorial Sloan Kettering Cancer Center in New York City. He has spent his entire career as a *salaried* physician in an academic medical center. He has not been involved with the efforts of the American Medical Association.

Dr. Lee's new office is on the ground floor of the Resident's Wing of the White House. It is Dr. Lee's intention, with the President's blessing, to upgrade his position "so that when I leave here — eight years from now — it is one of the premiere *health policy positions* in the nation."

During a recent interview Dr. Lee stated that he would consider as an option to control health care costs that all physicians in America be placed on a salary. Maybe we should interview the President's personal physician before determining how we should cast our

vote in the presidential elections.

The other occupant of the White House is Dr. Bill Roper. As you recall, he was recently the administrator of HCFA. Certainly most physicians did not agree with his proposals during the past four years.

With all the news and activities suggesting socialized medicine, I think it is necessary that we all look behind the scenes and realize that in many incidences there are a few people who are in key positions making choices for all Americans. I really do not think that the American public would be satisfied with the British or the Canadian system of health care. As physicians, we must move to the forefront and become more active in each of our communities and let people understand that we are the patient's friend, and we wish to maintain quality health care in the United States.

Historically, Americans respond well to challenges. I believe Alabama physicians are responding well to the challenges which they have faced during the past decade. Certainly, we are stronger and are more politically aware than we were at the beginning of the 1980s. We should continue to support local and state education programs, assist in funding the Arts, participate in environmental clean-up, support our local Chambers of Commerce and lead in support of the United Fund. We must let the people of Alabama know how much we really do care about them and our State. We simply must not stay in the background and avoid these responsibilities.

The lead article in the Mobile Press Register on Sunday, Nov. 19, 1989, outlined the devastation in Huntsville, Alabama. In that article it was noted that the Boeing Company had donated \$100,000 to the United Way to help with the relief efforts in the Huntsville area. In the same paragraph it was also noted that the Madison County Medical Society had contributed \$25,000. I am certain that those physicians gave far more to those in need during the long hours after the multiple tornadoes had touched down in their county. These quiet positive actions will not be forgotten when the fate of American medicine is ultimately decided by the patients of our country.

As you and your family join together for a restful and happy holiday season count your blessings and encourage each other. A gentle "pat on the back" for the medical community would be good for all of us. The never ending trail starts anew Jan. 1, 1990. A new year and a new decade will present many new challenges. We must be ready and willing to solve our problems together. I believe your patients really do appreciate you and your efforts. Yes, the struggle is worth it. There will be changes but not all of the changes will be negative. I believe the practice situation in Alabama will ultimately improve. I can still see a flicker of light at the end of this tunnel.

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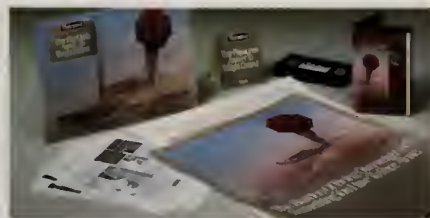
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Palliating Late-Stage Esophageal Cancer

Edward H. Laughlin, M.D.*

Abstract

Palliation for those with advanced cancer of the esophagus ideally should relieve dysphagia, stop aspiration, and sustain nutrition and hydration. Esophageal intubation with a Celestin prosthesis combined with Janeway gastrostomy is an excellent method for relieving the symptoms of advanced malignancy of the middle and lower thirds of the esophagus. Because intubation and gastrostomy do not require elaborate surgical facilities they can be performed in the community hospital. Although we have carried out the procedure in a small number of patients, palliation achieved has been such that we advocate intubation and gastrostomy as a quick and uncomplicated way to alleviate the symptoms of esophageal cancer patients with late-stage disease.

Although few persons with advanced esophageal malignancy are candidates for curative surgery, all require treatment to alleviate dysphagia and maintain nutrition and hydration. Because dysphagia is the most devastating sequela of esophageal cancer, restoration of swallowing should be the primary goal of palliation. Left untreated, individuals with esophageal malignancy will go on to complete obstruction, unable to swallow their secretions and at great risk for developing aspiration pneumonia.

The palliative treatment for esophageal cancer is unusual because of the many and varied methods of therapy that are available. No matter how diverse, as Postlethwait¹ notes, all methods of palliation should be directed toward the restoration of swallowing and maintenance of hydration and nutrition. Among factors to be considered in advising a particular type of palliative therapy are: (1) general condition of the patient

and extent of disease; (2) availability of specialized facilities such as radiation and laser; (3) desires of the patient and family.

We have used a method of palliation that combines esophageal intubation with a Celestin² prosthesis, and Janeway³ permanent gastrostomy. We believe that in most late-stage esophageal cancer patients intubation and gastrostomy offer the safest and easiest way to achieve the goals of palliation as outlined by Postlethwait.¹ The Celestin esophageal prosthesis is essentially a flexible funnel consisting of an ovoid mouth and long stem. It is formed of a coiled nylon strand imbedded in latex. The Celestin tube is a traction device pulled down the esophagus by means of a guide run up the esophagus through a gastrostomy. When correctly positioned the funnel shaped upper part seats against the tumor mass with the stem providing a passage into the stomach. The Janeway³ gastrostomy is a permanent opening fashioned from a gastric tube. Since it is continent this type of gastrostomy does not require bulky dressings and constant skin care to prevent skin irritation. Because the gastrostomy is lined with mucosa it does require an indwelling tube to prevent sealing over. Using a stapling technique devised by Ravitch⁴ creation of the continent gastrostomy, once a somewhat difficult technical maneuver, can easily be accomplished.

Procedure

The procedure is performed under light general anesthesia. At laparotomy the continent gastrostomy is fashioned using a gastrointestinal anastomotic (GIA) stapler to create a small gastric tube from the anterior stomach wall. An opening is made in the stomach through which a flexible guide is passed up the esophagus into the mouth. Traction on the guide attached to the lower part of the prosthesis the tube into the tumor mass. After the guide is removed, the distal end of the tube is shortened and sutured to the midportion of the stomach to prevent migration. The opening in the stomach is closed with the thoracoabdominal (TA) stapler after which all staple lines are buried with fine sutures. The gastric tube is pulled through the abdominal wall, through offset circular incisions in the an-

* Surgical Programs, School of Primary Medical Care, University of Alabama in Huntsville, Huntsville, Alabama 35801. Request for reprints to: 930 Franklin St., Suite 202, Huntsville, AL 35801

terior and posterior rectus sheaths and skin. Offsetting incisions keep the gastric lined tube from making a straight course through the abdominal wall, and assure continence. After the end of the gastric tube is amputated the mucosa is sutured to the skin, creating a permanent gastrostomy.

Results

Five patients with malignant dysphagia from advanced cancer were operated on. All procedures were carried out under general anesthesia. There were no operative deaths. Four of the patients left the hospital, and a fifth lived for several weeks able to swallow his secretions. There was one case of necrosis of the tip of the gastric tube resulting in stenosis of the stoma. All stomas were essentially continent and required no stomal management or particular skin care. Every patient received immediate relief from dysphagia. Except for elevation of the head of the bed no particular care was needed. Although every patient was able to swallow secretions following surgery none was able to satisfy all of his or her nutritional needs by mouth. All patients could swallow ground and pureed food by mouth, but every patient required supplementary feedings by gastrostomy to stem weight loss. Liquid medications were taken by mouth. All patients who left the hospital were free of intravenous medication and nutrients.

Discussion

Palliation of late-stage esophageal cancer can be achieved by means of: (1) dilatation and intubation; (2) esophageal resection and bypass; (3) radiation; (4) chemotherapy; (5) laser. Peroral dilatation, the time honored way of alleviating malignant dysphagia, although safe, inexpensive and rapid, requires the patient to undergo treatments that become closer together, more difficult, and more painful.⁵ Esophageal resection with immediate restoration of gastrointestinal continuity offers excellent palliation, but both intrathoracic and extrathoracic resections are formidable procedures with significant morbidity and mortality.⁶ Bypass of the obstructed esophagus also is a major surgical undertaking with drawbacks similar to those of esophagectomy.^{7,8} Radiation therapy can alleviate malignant dysphagia in most cases of esophageal cancer, but cannot be used in cases of tracheo-esophageal fistula or hemorrhage.⁹ Radiation is a demanding method of treatment that requires great investment in both time and resources.¹⁰ Chemotherapy can have significant activity in squamous esophageal cancer,^{11,12} but late-stage cancer patients often are unwilling or unable to tolerate the side effects of intense drug therapy. Laser therapy can relieve malignant dysphagia, but perforation occurs in up to 15% of cases so treated.¹³ Multiple courses given from three to 16 days apart are needed to complete laser therapy,¹⁴ and

like radiation, laser therapy requires specialized equipment. Intubation as a means of palliating mid and lower third tumors of the esophagus has been used for over 100 years, particularly in Great Britain and Europe.¹⁵ An esophageal prosthesis offers the person with advanced cancer immediate relief from difficulty in swallowing and aspiration, and enables the cancer patient to quickly resume oral intake of food and water. Esophageal intubation can be accomplished at an acceptable risk to the patient.¹⁶ Intubation of the esophagus is an excellent way of palliating malignant tracheo-esophageal fistula. Because esophageal intubation does not require complex surgical, radiation or laser facilities, it is widely available and relatively inexpensive to carry out. Being a traction tube rather than a pulsion tube, the tube, the Celestin prosthesis requires a gastrotomy for placement. Creation of a permanent Janeway gastrostomy adds little stress to the procedure of esophageal intubation. Because it does nothing to alleviate aspiration, gastrostomy alone must never be used to palliate malignant esophageal obstruction. Used in conjunction with intubation, however, gastrostomy enables the esophageal cancer patient to supplement oral alimentation. As Brennan¹⁷ notes, nutritional supplements increase protein synthesis and decrease catabolism; both of seeming benefit to the patient with esophageal malignancy. Because the Janeway gastrostomy is lined with gastric mucosa and is continent, no indwelling catheter is needed. This frees the patient and family from the problems associated with the tube gastrostomy—catheter dislodgement and skin irritation.

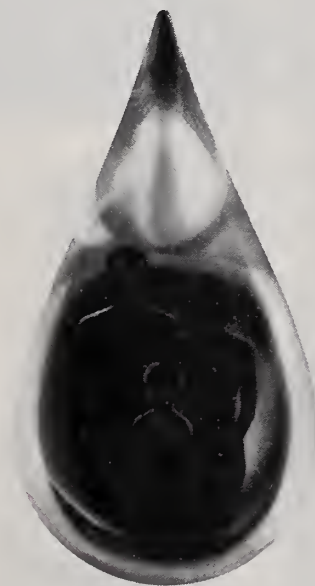
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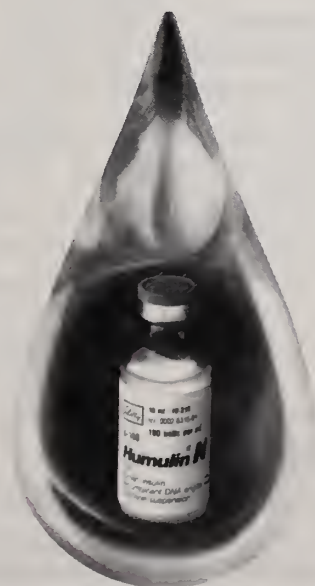
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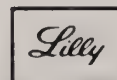


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Comparison of Alabama Behavioral Risk Factor Surveys

Melissa Galvin, M.P.H., Jim McVay, M.P.A.,
Jeffrey Roseman, M.D., Ph.D., M.P.H., Nalini Sathiakumar, M.D., M.P.H.

Introduction

In an effort to reduce medical care cost, prevent the onset of disease and thereby improve the quality of life in the United States, a new emphasis has been placed on self-responsibility for health. In order to assist individuals in the selection of healthful activities, it is necessary to identify health problems and the extent to which activities that influence these problems are, or are not, engaged in by individuals.

It was for this purpose that the Centers for Disease Control initiated the Behavioral Risk Factor Survey. In 1982, 1986 and again in 1987 Alabama's Bureau of Primary Prevention Department of Public Health participated in this program. The objective was to determine the prevalence of certain risk factors among randomly selected adults (18 years or older) in the State of Alabama. High blood pressure, hypertension compliance, alcohol usage, cigarette usage, obesity, exercise and seat belt usage were the risk factors under study. In 1987, information on preventive health practices was also collected. All risk factors were analyzed by age, race, sex and educational level. The purpose of this paper is to examine the changes in prevalence which have taken place over this period of time.

Methods

In 1982, 1986 and 1987 telephone surveys were conducted covering the entire state of Alabama in an effort to assess the prevalence of risk factors of morbidity and mortality. A random sample of telephone numbers was selected from all possible phone numbers. Only residential numbers were used in the survey.

In 1982, a telephone survey was conducted using a random-digit dialing procedure of 696 households, this survey was conducted over a period of three weeks. In 1986, a total of 559 and in 1987, 1,182 households

were contacted. The 1986 and 1987 surveys were conducted over a period of 12 months, in an effort to reduce seasonal bias. Given these sample sizes, the standard errors of estimate are 1.9% in 1982, 2.2% in 1986, and 1.5% in 1987. In order to minimize within household availability bias, the individual interviewed was randomly selected from all household adults over 18. The respondent was selected by using a matrix of the last digit of the telephone number and a list of available adults arranged by age. Before the interview, an informed consent was obtained from the respondent. The survey instrument has been revised and some questions have been deleted. The difference will be noted in each section.

Although a telephone survey is a quick and effective means to collect data, it does have limitations. In 1978, 89% of the households in Alabama had telephones. Although this figure has increased steadily each year with 93% of the households having telephones in 1986, this still deletes the very poor and some rural residents from the survey population.¹

Results

The statewide samples were similar to the 1980 census figures with a 5% margin for sex, 7% for race, 9% for age and 11% for education categories (Table 1).² Males are consistently under-represented, especially black males. Individuals who have less than an 11th grade education are also under-represented.

Seatbelt Usage

There has been a significant improvement in seatbelt usage. In 1982, only 13.5% of the respondents always or almost always wore seatbelts. By 1986, 36.8% and by 1987, 44% always or nearly always wore their seatbelts. In 1986, 47.6% and in 1987, 30.3% of the

Table 1
Comparisons in Demographic Profiles of the 1982 and 1986 Statewide Samples by 1980 Census Data

	<i>1982 Samples %</i>	<i>1986 Sample %</i>	<i>1987 Sample %</i>	<i>1980 Census %</i>
Sex:	(n = 696)	(n = 559)	(n = 1182)	
Male:	43	39	38	48
Female:	57	61	62	52
Race:	(n = 687)	(n = 543)		
White:	77	83	76	74
Black:	23	17	24	26
Age:	(n = 696)	(n = 559)		
18-24	15	12	17	19
25-44	41	39	38	38
45-64	24	24	29	27
65 +	20	25	16	16
Education:	(n = 694)			
0-11th grade	36	30	26	41
High School and some college	48	53	59	48
Four years of college or more	16	17	15	11

respondents never or seldom wore their seatbelts, compared to 60.2% in 1982 (Table 2).

Respondents reporting they "sometimes" "seldom" or "never" use seatbelts are closer to validation studies of seatbelt usage. In 1986, 63% and in 1987, 55.8% of the respondents fell in this category, compared to 78.2% in 1982. Age, sex and race were not linked with seatbelt usage. As education and income increases so does seatbelt usage. These trends are consistent for all three surveys.

Hypertension

In the 1982 survey only 1% of the respondents had never had their blood pressure checked; (CDC deleted the question in 1986). In 1982, 28% of the respondents had been told they have high blood pressure compared to 18.6% in 1986 and 24.9% in 1987. In all three years, females were more likely to be diagnosed hypertensive (significantly more likely in 1982). Of those who had been told, only 69.9% in 1986 and 67% in 1987 reported they had medicine prescribed, compared to 86.5% in 1982. Also, 96.0% of the respondents in

1986 and 94.6% in 1987 stated they take their prescription regularly, while only 78.4% of the 1982 respondents were apt to take their medicine (Table 3).

Hence, only 2.2% in 1987 and in 1986 1% reported they still had high blood pressure compared to 20% in 1982. Blacks were at least twice as likely to have persistent high blood pressure than were whites in all surveys. In 1982 and 1986, there was no significant difference between male and female, but in 1987 2.9% of women compared to 1.4% of men had persistent hypertension.

Exercise

The questions on exercise vary tremendously, therefore, no reliable comparison can be made. CDC computed the sedentary activity level for 1986 at 60.9% and 59.0% in 1987, which were respondents at sedentary or irregular activity.

In 1982, 43% reported they never exercise. CDC reported 12% had a sedentary lifestyle which was defined as "a combination of a sedentary occupation, less than 1 hour per month of vigorous physical exercise and fewer than three times per week of moderate physical activity."

Males and whites were slightly more apt to exercise than females or blacks. There was no consistent trend

Table 2
1982, 1986 and 1987 Seatbelt Usage

	<i>1982 %</i>	<i>1986 %</i>	<i>1987 %</i>
Always	13.5	36.8	43.7
Sometimes	6.3	17.2	25.5
Seldom	18.5	18.5	11.8
Never	60.2	27.1	18.6
Unknown/Refused — Never Ride in Car	1.5	0.4	0.5

Table 3

	<i>1982 %</i>	<i>1986 %</i>	<i>1987 %</i>
High Blood Pressure	28	18.6	24.9
Rx Prescribed	86.5	69.9	67
Rx Taken Regularly	78.4	96.0	94.6
BP Still High	20	1	2.2

Table 4
1986 and 1987 Respondents
At Risk for Sedentary Lifestyle

	1986 %	1987 %
0-11th Grade	69	68
High School/some college	59	59
College Grade	52	46

with age and exercise, except 18-24 years were more likely to exercise than any other age group. An inverse relationship existed between education and those at risk for sedentary lifestyle (Table 4).

Obesity

In 1982, 24.4% of the respondents were obese, compared to 22.9% in 1986, and 25.2% in 1987. Obesity is defined as at or above 120% of ideal body weight. Ideal body weight is defined as the mid value of a median frame person from the 1959 metropolitan height-weight tables.³

In 1986 and 1987, blacks had significantly more obesity (Table 5) than whites. There were no consistent trends for sex, education and income.

Cholesterol Levels

Questions on cholesterol were asked in 1982 and 1987, but omitted in 1986. Eleven percent of the respondents in 1982 reported their cholesterol level was high compared to 7.6% in 1987. The differences by sex, education and race were not significant. Results of both the 1982 and 1987 surveys show that as age increases so does cholesterol level.

Cigarette Usage

In 1982 31% of the respondents stated they were smokers, which dropped to 24.6% in 1986. Yet, in 1987 there was an increase to 27.2%.

Men are more likely to be smokers than women (Table 6), while blacks are more likely to be smokers than whites (Table 7). In all three years, as educational attainment increases cigarette smoking decreases.

Alcohol Usage

Acute alcohol use is defined as having five or more drinks on an occasion, one or more times in the past month. In 1986, 10.2% of the respondents reported acute drinking episodes as compared to 14.9% in 1982. In 1987, there was an increase of acute drinking episodes to 12.5%.

Table 5
Obesity by Race

	1986 %	1987 %
Black	43.2	32.6
White	20.7	25.5

Table 6
Smokers by Sex

	1982 %	1986 %	1987 %
Male	39.0	30.6	31.3
Female	25.0	19.3	23.5

Table 7
Smokers by Race

	1982 %	1986 %	1987 %
White	32.0	23.7	26.4
Black	29.0	31.7	30.8

Table 8
Acute Drinking Episodes vs. Sex

	1982 %	1986 %	1987 %
Male	24.0	18.7	18.6
Female	6.0	2.4	6.2

No significant difference was noted in race, but males were significantly more likely to have experienced acute drinking episodes than females (Table 8). Individuals under age 45 were much more likely to have experienced these episodes than were individuals over age 45.

Chronic alcohol use is defined as an average of 60 or more alcoholic drinks a month. Chronic alcohol

continued on page 20



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continued from page 17

usage was 4.4% in 1982, 1.6% in 1986, and 5.6% in 1987.

Again more men were likely to be chronic alcohol users than women (Table 9). No significant difference was noted by race.

Respondents who report having driven after having too much to drink, one or more times in the past month showed no change in the two surveys. In 1982, 4.7% drove under the influence of alcohol, increasing to 5.4% in 1986 with a slight decrease in 1987 to 2.6%.

No significant differences were noted for race, but again men drove after having too much to drink more often than women (Table 10).

Preventive Health Services

In 1987, additional questions were added on physicians visits, flu shots and mammograms. Results show the majority (71.1%) of individuals have visited a physician within the last year for a routine checkup. Females (75.0%) were more likely than males (60.5%) to have a routine check-up in the last year.

No significant differences were noted in age with the exception of individuals over 65, who are more likely to have visited their physician in the last year (77.9%) than are those below 65 (66.4%).

Only 15.3% of the individuals responding had received a flu shot within the last 12 months. Men (17.8%) were slightly more likely to receive a flu shot within the last 12 months than females (13.1%). As expected, as age increases so does prevalence of receiving a flu shot. The UAB, Center for Aging and the State Commission on Aging conducted a door to door survey of Alabamians over age 55; of those surveyed 29.9% of the males compared to 30.3% females had received a flu shot within the last 12 months.⁴

Almost 90% of women asked had heard of a mammogram, with no significant differences noted by age. The number of women who had ever received a mammogram by age is shown in Table 11. In the Statewide Survey of Alabama's Elderly 57% of women over 55 had received mammogram.

Discussion

These Behavioral Risk Factor Surveys are the ideal tool for all health care workers in Alabama which can

Table 9 Chronic Alcohol Use by Sex			
	1982 %	1986 %	1987 %
Males	11.0	2.9	10.4
Females	4.0	0.5	1.3

Table 10 Drinking and Driving by Sex			
	1982 %	1986 %	1987 %
Males	8.0	10.6	4.1
Females	2.0	0.7	1.4

Table 11 Mammogram by Age	
	1987
18-24	11.6%
25-34	17.2%
35-44	40.7%
45-54	53.8%
55-64	41.3%
65 +	43.0%

be used for baseline data and educational efforts. These surveys are very useful when compared, to measure changes over time, effects and progress of programs (Table 12). For example this information can be used to assess progress toward the 1990 "Objectives for the Nation" set forth by the Department of Health and Human Services.⁵ They provide information which can be used for program planning to determine where emphasis should be placed. CDC has pledged to continue the surveys, refining the instrument and adding pertinent questions. For example, the 1988 survey asked respondents if they are in favor of sex education in public schools.

Ninety-two percent of individuals killed in car accidents in 1987 were not wearing their seatbelts.⁶ Even though, from 1982 to 1987 Alabamians have increased usage rates it is still below the national estimate of 55% always or nearly always using seatbelts.⁷ Public education campaigns must continue and laws for mandatory seatbelt usage require further consideration. The association with education suggests directing educational efforts at those with lower educational attainment.

As noted, blood pressure screening is so extensive that the question concerning screening has been deleted from the survey. Hypertension has consistently been more of a problem for women. In 1982 Alabama led all surveyed states in persistent hypertension. Persistent hypertension in Alabama is still a major problem. Although, the national estimate for persistent hypertension is 4%⁸; in 1987 8.8% of Alabamians had persistent hypertension. It must be noted that from 1982

TABLE 12

	1982	1986	1987	U.S. 1986	1990 Health Objectives for the Nation
<i>Seatbelts:</i>					
Never/Seldom	60.2	45.6	30.4		
Always/Nearly Always	13.5	36.8	43.7	55%	—
<i>Hypertension:</i>					
HBP	28.0	18.6	24.9		—
Rx prescribed	86.5	69.9	67		—
Rx taken	78.4	96.0	94.6		—
Still HBP	20.0	1	2.2	3.9	—
<i>Exercise</i> (questions vary)	43 (never)	60.9 (at risk)	59 (at risk)	60%	—
<i>Obese:</i>	24.4%	22.9%	25.2%	22%	14%
<i>Cigarette Usage:</i>					
Current smoker	31.0%	24.6%	27.2%	30.5%	25%
<i>Alcohol Usage:</i>					
Acute	14.9	10.2	12.5	22.7	—
Chronic	4.4	1.6	5.6	8.4	8%
Drink/Drive	4.7	5.4	2.6	6.2	—

to 1987 there has been a decrease in high blood pressure medication prescribed, which may have contributed to the increase in persistent hypertension.

The questions on exercise vary so much it is difficult to determine any trend. One trend is firmly established; Alabamians are "couch potatoes." Alabamians risk sedentary lifestyle is 59% in 1987 compared to the national rate of 60%.⁹ National estimates state that only 7-8% of adults participate in exercise 3 or more times a week for a minimum of 20 minutes.⁹ This is certainly an area which needs intervention. This is reinforced by the fact that Alabamians are more obese (25.2%) than the national average (22%).⁸ While the 1990 health objective for the Nation is that less than 14% of Americans will be obese. The increased prevalence of obesity in blacks, particularly, black females, and their lack of exercise suggests that this is a group which needs additional attention.

Cigarette smoking is still a major problem, but since 1982 there has been a steady drop in smokers. Alabama seems to reflect the national trend with 27% of individuals statewide and 30.5% Nationally reporting they are current smokers.¹⁰ To reach the Nation's objective less than 25% of the population by the year 1990 are smokers, education programs need to be continued with emphasis in the schools, especially in the elementary and junior grades.

Acute alcohol consumption (12%) is less than national estimate of 22.7% as well as chronic consumption of 5.6% compared to the national average of 8.4%,⁸

while the 1990 Health Objective is 8%. The awareness of mandatory-punitive measures and public education campaigns have aided in the decrease of individuals drinking and driving to 2.6% in 1987 while the national estimate is 6.2%.¹¹

This data should be useful to determining areas of concentration for future programs. The quality and quantity of life depends greatly on how we care for ourselves. With this information we can begin to understand and decrease risk factors of morbidity and mortality. □

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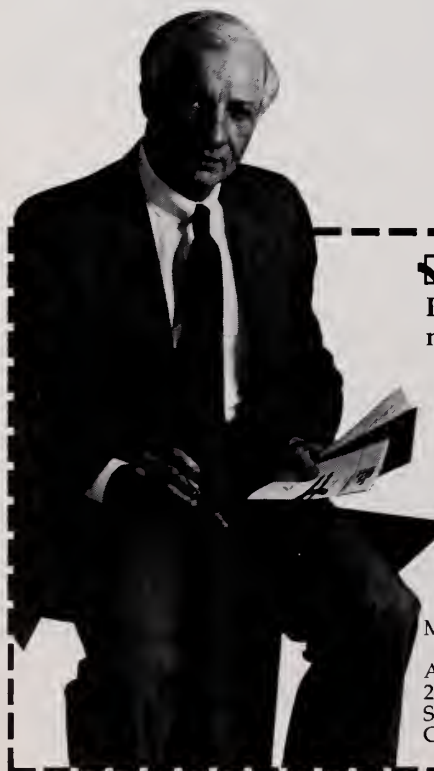
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New and Future Treatment of Depression

James F. Hooper, M.D.*

In 1983, we published an article on "The Coming Generation of Antidepressant Therapy."¹ At that time we spoke of the rapid changes that were occurring in biological psychiatry, with a host of "second generation" drugs coming to market. As is often true of soothsayers and fortune tellers, the future has not turned out exactly as we predicted it would. This paper is an attempt to update what is out of date from six years ago, and to once again peer towards the future of antidepressant therapy.

History

To understand anything of antidepressant drug treatment, one must understand that it is all built on sand. It was empirically discovered that some compounds alleviated depression, and researchers have been trying to tie down exactly how ever since. Most neuro-physiologic theories are connected to the "biogenic amine" hypothesis. Loosely stated, this says that some depressions are a result of a relative insufficiency of the neuro-transmitter serotonin, while others are due to a lack of norepinephrine. Psychiatrists still argue about the relationship of stress to this lack, and we are quite sure that other neuro-transmitters have at least some bearing on mood, but no one had an exact picture yet. Monoamine oxidase inhibitors (MAOI's) correct this by decreasing oxidation of neuro-transmitters. Tricyclics (named for their molecular triple ring structure) are generally regarded as re-uptake blockers, yielding a relative increase at the synapse by decreasing re-absorption. In line with these theories, "tertiary" amines (such as amitriptyline and imipramine) are

stronger blockers of serotonin re-uptake, and are therefore best for "serotonin-low" depressions. Secondary amines, such as desipramine and nortriptyline) are better at "norepinephrine-low" depressions. Unfortunately, no clinical method yet tried has been able to clearly predict who will respond to which drug.

Although it is true that almost every study ever done has shown a response rate to drug therapy of about 70%, different populations make up the 70% of any given drug. Thus, if one drug fails, a logical second choice has about a 50-50 chance, and every antidepressant has some special sub-group for which it is best. Patients should truthfully be tried on every antidepressant in a large enough dose for a long enough time before being described as "non-responders."

Old Drugs

MAOI's (Nardil, Parnate) have been around for many years. They are effective and generally safe, but can have inter-reactions with other drugs and some foods, and are therefore often avoided. Their lethal dose is less than ten times an average daily dose. Recent research has pointed out that isocarboxazid is also effective in depression,¹ but the difference between its effect on such things as "blaming others" and that of tricyclics points up the subtle difference in the drugs.

Tricyclic antidepressants are the mainstay of drug therapy in the United States, and have been available since the mid sixties. These drugs are effective in a large number of patients, but are limited by their common side effects such as dry mouth, constipation, and blurred vision, which impair compliance and often lead to false treatment failures. These drugs have an undeserved reputation for causing arrhythmias which essentially do not occur except in overdoses. Their lethal

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dose is approximately thirty times an average daily dose.

One tricyclic deserves a special comment. Clompramine (Anafranil, CIBA-Geigy) is currently available in every country on Earth except the United States. The exact reasons for this remain a mystery. It has been clearly shown to be effective in obsessive-compulsive disease, as well as typical depressions. Since it is legal to fill a prescription for this drug for oneself and bring it into this country personally, but not legal to ship it through the US mails, we have strange system where patients living near Canada or Mexico can be treated with a drug that people in Alabama are essentially denied. Clinical trials creep forward here, and perhaps before we retire obsessive patients will be able to use this medication.

More Recent Drugs

Amoxipine (Asenden, Lederle) is a tricyclic derivative of Loxitane, a non-phenothiazine anti-psychotic. Since this drug can cause tardive dyskinesia, its use is very limited.

Maprotiline (Ludomil, CIBA-Geigy) was the first tetra-cyclic compound introduced in the US market. Widely used in Europe, and similar to desimpramine, but more sedating, this drug has a relatively high incidence of Grand-Mal seizures, and its very expensive and intensive marketing has not produced enough converts to make it a common drug.

Alprazolam (Xanax, Upjohn) was first marketed as simply another benzodiazepine, but evidence continues to mount showing a true anti-depressant effect.

Second Generation Drugs

These drugs as a group are characterized by much safer overdose profiles than older therapies.

Trazadone (Desyrel, Mead-Johnson) was released in March of 1982, and was the first really new compound on the US market in 15 years. This drug has a generally low side-effect profile and is frequently more rapid in onset than tricyclics. It appears to be a serotonergic type antidepressant, and has few anti-cholinergic and virtually no cardiotoxic effects. It has been reported to cause priapism, and some physicians avoid it in men for this reason, though the incidence of this is rare enough that it is unlikely to occur. Desyrel is not as "broad-spectrum" as tricyclics, and in our experience either works very well and quite fast, or not at all.

Fluoxetine (Prozac, Dista) is just now entering its second year on the US market. A bicyclic compound, this remedy has been very impressive in the three years we have had experience with it. Interestingly, this is a very pure serotonin re-uptake blocker, with no antihistaminic effects, and it does not produce the dry mouth, sedation or weight gain associated with tricyclics. Prozac has been shown to have significant

anti-obsessive properties³ and in our experience is quite useful in the treatment of anorexics. It may be that since other antidepressants have been found to have some benefit in anorexia, that Prozac simply works as they do, but we believe that it is more specific than that. Fluoxetine itself has a half life of two to four days, and its active metabolite, desmethylfluoxetine stays in the body for well over a week.

Perhaps on the Horizon

Bupropion (Wellbutrin, Burroughs Wellcome) has an almost history. We used this drug with more than 60 patients over a four year period, and felt that it was one of the most amazing therapies ever to come down the trail. It has neither serotonin nor norepinephrine re-uptake blocking, but instead acts on dopamine, which should make it an anti-psychotic. It is not a neuroleptic, however, and has much the same side effect profile as fluoxetine. This drug can cause sleeplessness and weight loss, though like other third generation drugs it is not a true appetite suppressant, and should not be used for dieting. We have seen patients who were so vegetative in their depression as to be almost catatonic by clinically well in four days on Wellbutrin. This drug was actually approved by the FDA and shipped in 1985 to pharmacies, but was recalled the next day, because some seizures had been found in anorexic patients. It was our experience that Ludomil caused far more seizures than Wellbutrin. Since the latter drug has absolutely no known cardiovascular symptoms even in massive overdoses, it will some day be the drug of choice in post-infarct patients. Interestingly, although Wellbutrin has essentially no anti-cholinergic symptoms, it is concentrated in the saliva, and therefore can produce a dry mouth without any other typical symptoms.

Fluvoxamine (sold in England as Favine, and in Europe as Floxyfral) is quite similar to Prozac except that it has a brief half-life, necessitating multiple daily doses, but also allowing quick weaning if any problems develop. It is also is a bicyclic compound, and both of these drugs share a phenomenon which we have called "the yawns" in that patients with these drugs will have occasional episodes of uncontrollable yawning. Floxyfral has been on the market in parts of Europe for at least five years. It has also been shown to have some efficacy in obsessive-compulsive disorders.

l-Deprenyl, an atypical MAOI specific for monoamine oxidase B, is available for the treatment of Parkinson Disease in Europe. The Hungarian company that developed it apparently does not feel that the slight evidence of it being safer than other available MAOI antidepressants warrants the cost of FDA regulations. Perhaps someday they will pursue a market as an antiparkinsonian, and then we will be able to try it out.

Etoperidone (McNeil) is currently ending Phase II trials in the US, and may be on the shelves by 1991

or '92. Its effectiveness remains a trade secret at this time.

The utility of lithium salts in mania is of course universally recognized. Twenty years ago it was suggested that since the body treated lithium almost the same as the two closest relatives in the periodic table, sodium and potassium, that perhaps rubidium should be explored as being on the opposite side of the light metals, and perhaps opposite in effect on mood. Most of the research on this has been done in Italy, but clear evidence the rubidium salts can improve depression exist, and deserve further exploration.⁴

Never Again

Mianserin (Bolvidon), a tetracyclic was originally scheduled for release in the US in 1984. It was reported to have a therapeutic range similar to imipramine. One study, at least, however, indicated that it was only useful in less severe depressions, and the FDA wanted more proof of efficacy before approval for major depression. By that time, the patent was nearly expired, so the Dutch company that had developed it gave up on the US market.⁵

Zimelidine (MSD) was released in some countries, including Sweden and Canada, but was withdrawn from the market just before release here due to an unexpected increased risk of Guillain-Barre syndrome.

The story of Nomifensine (Merital, Hoechst-Roussel in US, Alival in Europe) is a true tragedy. This drug was released (as are most) in Europe years prior to its sale in the US. It did reach the market here, however, for a short time, and our experience with it was that it was extremely effective in otherwise treatment resistant patients. Merital had a higher than expected incidence of drug fevers, and there were a few deaths in England. The company withdrew the drug from sale or even production world-wide, because the US market is so litigious that no one can afford the impact of a well-publicized problem. In this instance, not only are patients here deprived, but depressed people in Argentina and Pakistan are left to suffer because our courts can bankrupt a company.

The issue that all doctors face, not only in psychiatry, is one of safety versus utility. Just as any drug that might remotely cause cancer is prohibited, so drug companies have to fight a long and incredibly expensive battle to prove safety and efficacy. In this country, a competent adult can buy cigarettes with a label that say "this will kill you" in any State in the Union. The same person, if depressed, is denied access to useful treatment. Hopefully, if this article is updated in six more years, that will be less true. □

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Family Medicine Education in Alabama

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In the late 1960s the Medical Association of the State of Alabama, as represented by the Alabama Academy of General Practice, began to collect data to lobby the Alabama Legislature and the Governor's office to expand the funding for training in Family Practice. The goal of this effort was to place more physicians in underserved, rural Alabama. Dr. William Willard, a prime mover of this mission, has stated "in 1980 forty-four counties in Alabama and parts of fifteen other counties are critically short of physicians!"

The purpose of this paper is to present a brief overview of the history and goals of the family medicine movement that occurred in Alabama around 1970. A second focus is to take a practical view of how one residency program, the Montgomery Family Medicine Residency Program, is meeting these original goals as of 1989. As a part of this history excursion, the authors had the pleasure of interviewing some of the early leaders who spearheaded this movement, including Governor George Wallace, Dr. Dick Hill, Dr. Jim Pittman, Dr. Gayle Stephens, Mr. Clyde Cox, and Dr. Charles T. Moss, Jr.

In 1969 one-sixth of the physicians in Alabama were engaged in full-time general practice, and one-half of Alabama's counties received all of their professional medical care from general practitioners.² The Academy went on to assert that the state needed challenging and broad-spectrum programs to train family physicians to meet the growing health care shortage in primary care facing rural Alabama. Dr. Willard's report, based on GMENAC statistics speculated that Alabama

would need 1,670 more primary care physicians by 1990.¹

Governor George Wallace was campaigning for his second term as Governor of Alabama in the spring of 1970. From his own roots in rural south Alabama and from the point of view of his Populist political philosophy, Governor Wallace was well aware of the physician shortage in most Alabama counties.³ In his characteristic and now famous political vision, Governor Wallace successfully parlayed this problem and his proposed solution into a campaign issue. As usual, in the long run, the average citizen of Alabama came to benefit from his efforts. As a result, Governor Wallace is generally credited with leading the drive that has resulted in the family medicine education system in Alabama as we know it today.

During the campaign it was not unusual to hear Governor Wallace asking a crowd in a supermarket parking lot political rally, "Do y'all need doctors in this county?" Of course, they did, and we still do in most of rural Alabama. He was also prone to say, "We'll have enough doctors when you can get one to make a house call on Sunday." We have Governor Wallace and the early leaders in this movement to thank for improving the situation to current levels; yet, there are still major shortages present in rural Alabama.

It is a major thesis of this paper that the Family Medicine Residency system continues to represent the best and most well-rounded solutions to problems in the health care system of this state. The development of the discipline of Family Medicine in the late 1960s was a move away from specialization of urbanized medicine. Family Medicine instead emphasized care of ambulatory patients, comprehensiveness/continuity

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In 1976 the Alabama Academy of Family Physicians issued a policy statement that recommended an increase in funding of graduate medical education in Family Practice to increase available first-year training slots in family practice from 32 to 115.⁴ This recommendation was based on the Supplemental Report of the Physician Manpower Study (February 17, 1976) which was prepared for the State Committee of Public Health by the Comprehensive Health Planning Administration, Alabama Department of Public Health. The Academy pledged its support to the Alabama Legislature to work in an advisory capacity to assure adequate funding and orderly expansion of programs.⁵

This progress is best documented by an early leader in Alabama Family Practice, Dr. G. Gayle Stephens who stated, "There is no doubt that the appropriation of state funds by the Alabama Legislature in 1971 was the catalyst for the initiation of family practice education."⁵ In January of 1981, Dr. Stephens published a report that documented substantial growth as a result of these efforts. At that time, eight programs (Anniston, East End Memorial, UAB, Selma, Montgomery, Gadsden, Tuscaloosa, and Huntsville) had provided graduate medical education for 244 residents (1973-80), producing 82 graduates. Of those graduates, 52% were making their home and practice in Alabama. The net gain of 58 family physicians was seen as a substantial movement toward the original goals of this effort. It is also worth noting that state monies account for only about 40% of the average operational costs of these programs and that local community support and practice earnings provide over 50%.

In 1979, Governor Fob James faced a prorated budgeting problem in his efforts to fund education in Alabama from elementary education to graduate medical education. At that time, Dr. Gayle Stephens again successfully lobbied to secure level funding for graduate medical education. In a March 28, 1989 letter to Governor James, Dr. Stephens stated, "It would be poor economy to dismantle or strangle these programs just when they are ready to produce more of what is needed. The state has invested \$25-\$30 million in family physician education since fiscal year 1972-73, and we now need \$2 million in 1979-80 to operate the five programs in Anniston, Birmingham, (East End), Gadsden, Montgomery, and Selma."⁶

Progress has been made in that now programs are operational, and as of July 1, 1987, 168 future family physicians were in training.⁷ Of the 405 residents graduated statewide, 227 have stayed in Alabama (56%) and 114 of this number (51%) are practicing in rural areas. Because of reduced funding, increasing mal-

practice rates, and inflation, the Alabama Academy of Family Physicians continues to lobby the Alabama Legislature for increased funding. In 1987 this request was 40% over 1986 level funding.⁷

Data from the Alabama State Health Planning Agency reveals physician maldistribution, both by specialty area and geographically.⁸ This data points out that while both are still lacking in Alabama, rural health care and the Alabama family physician are well matched. Further, it is suggested that increasing the number of family physicians is necessary in order to begin to meet the demands of the obstetrical crisis in rural Alabama. As stated in a recent position paper, "The only major hope for offsetting the obstetric crisis for rural Alabama will be to reintroduce those family physicians who have quit delivering babies and/or to produce new family physicians from present training programs to replace those who quit OB presently" (p. 1).⁸

The Montgomery Family Medicine Residency Program takes particular pride in presenting data about our graduates. While, in the words of Robert Frost and Governor Wallace, there are "miles to go before we sleep," we feel that we are meeting some of the goals of the founders of the family medicine movement in Alabama.

As of July 1988, 22 residents (19 men, 3 women) have completed their three-year residency in Family Medicine in the Montgomery Family Medicine Program. Eleven of these residents are Alabama natives, ten of whom were educated in one of our state's two medical schools. Four were educated at the University of Mississippi Medical Center, five were educated in foreign medical schools, one at Meharry Medical College, one at Howard Medical College, and one at Loyola University of Chicago. Eighteen of the twenty-two graduates (82%) are now Board Certified by the American Board of Family Practice. Only two residents have failed their boards (9%) and two are currently waiting to take the exam. If these latter two pass, we will have a current pass rate of 90% for Board Certification. In addition, as of February, 1989 the program was fully re-accredited with AMA approval.

Twenty of our graduates, an astounding total of 91%, are currently practicing in Alabama, even though only one-half of them hail from Alabama. This compares to a statewide retention rate of 56%. Seven (31%) have located in the Montgomery area. One is working for the Alabama Department of Public Health and rotates his time between six rural practice locations in Lowndes, Butler, Elmore, Autauga, Dale and Montgomery counties. Twelve residents (55%) are in cities of less than 20,000 population and eight (36%) are in towns of less than 5,000 people. Thus, 64% are practicing in relatively "rural" parts of the state compared to 51% among programs statewide.

In summary, these data reveal that the Montgomery

Family Medicine Residency Program is successfully making progress in meeting the early goals of the Family Medicine Education movement in Alabama. The key factors in measuring this progress are the high retention rate of 91% practicing in the state and 64% choosing to practice in rural areas. The program is committed to the goals of continuing to recruit highly qualified residents who have intentions of continuing these positive statistical trends. The state-wide network of family practice residency programs is worthy of continued state and local support because the system is helping address the problems of distribution of primary care physicians around the state. The health care

needs of all Alabamians, particularly rural Alabamians, depend on the continued existence and support of these programs. ■

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*Mrs. John O. Hardiman
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We Share Because We Care — AMA-ERF

AMA-ERF — the magic letters! Do you know what they stand for? For some they stand for hope; some, finishing medical school; some, additional uncommitted funds to hire specially-qualified instructors to aid in the training of new physicians; for others, the wherewithal to accomplish that extra bit of research that just may come up with a cure for cancer or AIDS patients. Wouldn't that be magic to all of us?

AMA-ERF, the American Medical Association Education and Research Foundation, was begun by the American Medical Association in 1951 to fill a need for funds for excellence in medical education. In 1953, the AMA called upon its Auxiliary for assistance in this project. The Auxiliary quickly responded, and for the past 36 years has made fund raising for AMA-ERF its sole nationwide philanthropic endeavor.

The Medical Education Loan Guarantee Program for 18 years (1962-1980) helped many qualified young people finance their medical education and training. Over \$95 million in guaranteed loans benefitted medical students, interns, and residents. Regrettably, conditions in the general economy forced suspension of new lending through this program by participating commercial banks in 1980.

Through the years, the Foundation has distributed gifts of more than \$48 million in unrestricted grants directly to the nation's medical schools, primarily because of the generosity of the medical families of the

nation and the dedicated fund-raising efforts of the AMA Auxiliary. This has helped to insure quality medical education and assist in research in the nation's medical schools.

Contributions may be made to the AMA-ERF's Medical School Excellence Fund, the Medical Student Assistance Fund, or the Unrestricted Fund. The money you give can be designated to benefit the medical school of your choice — perhaps your alma mater, or a new school in your area, or a school that is doing research in some field in which you have particular interest. These donations are used by the schools in a variety of ways — building improvements, faculty salaries, library books, or student loans and grants. Medical School Excellence Fund gifts are unrestricted; the school may use the money to best meet its needs. However, if you wish to designate a specific use for a gift, your wish will be honored if at all possible.

Through the Medical Student Assistance Fund, a restricted fund established in 1983, contributions can be donated to benefit students at a particular medical school. These gifts are used for direct student assistance to help students pay educational expenses. Donors contributed nearly \$600 thousand to this fund in 1988.

A gift to the Unrestricted Fund can help support research to special health/medical programs, or it can provide needed grants for other projects within the

AMA-ERF's scope of interest. For example, grants from the Unrestricted Fund in one year supported student medical research forums, work on alcoholism, research on the effects on children of a drug taken by their mothers during pregnancy, and applications of the computer to medicine. All requests for AMA-ERF grants must be approved by the Foundation's Board of Directors.

Another facet of AMA-ERF grant activities is the Categorical Research Grant Funds which award grants from contributions restricted by donors to research in such fields as neuromuscular diseases, metabolic and endocrine diseases, neoplastic diseases, cardiovascular and pulmonary diseases, and arthritis and rheumatism.

Nationwide contributions to AMA-ERF in 1988-1989 totaled \$1,872,247.91. Alabama physicians and spouses contributed \$54,895.32. This seems like an enormous amount. However, with spiraling costs and shrinking government subsidies, medical schools increasingly must depend on private sources to help meet the educational needs of America's future physicians.

An easy way to contribute to AMA-ERF is through your County Medical Auxiliary's Christmas Sharing Card. The sharing card works like this: you donate your money to your County Auxiliary, designating the school and/or fund to which you would like your contribution to go; a committee of Auxiliaries from your county sends a greeting card at Christmas to all the physician families in your county, including the names of all physicians/spouses that have donated to AMA-ERF; the medical school of YOUR CHOICE receives the money to carry on its good work, and you have the additional joy of sharing part of what you have been fortunate enough to receive with students who are struggling to get through medical school, or with medical schools for research or improvements. You will know that you have helped improve the health and quality of life for some of your fellow citizens. This past year over half of AMA-ERF funds were raised through Christmas Sharing Cards.

Such diversity! I know that each of us can find at least one area of interest to open our hearts and financial resources to aid AMA-ERF! If your county does not have an organized Auxiliary, you may send a contribution direct to our state AMA-ERF Chairman, Mary Ann Lafleur, 304 Dogwood Lane, Mobile, AL 35020. □

Mary Ann Lafleur



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(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed. Caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General:* **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucoside, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Dther: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Dther (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium. (See PRECAUTIONS.)

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance <30 mL/min (serum creatinine >3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >16 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information: Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19386. JVS16R2(8171)

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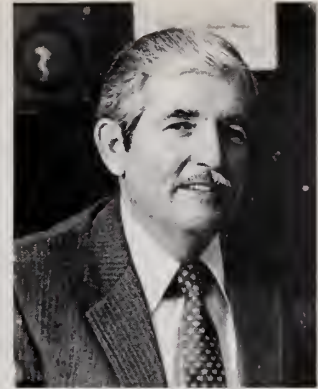
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EXECUTIVE DIRECTOR



S. Lon Conner
Executive Director, MASA

An RBRVS Dissent

In rapidly changing times of great complexity and uncertainty, it is sometimes instructive to consider a viewpoint diametrically opposed to your own. Such an exercise serves to focus your thoughts in a way that may be absent when all you hear are opinions compatible with yours.

Congress recently passed a Resource-Based Relative Value Scale for Medicare physician reimbursement. The concept was endorsed by AMA and by MASA. Obviously, a clear numerical majority of American physicians support it. But there are some eloquent dissenters, whose views should test our own convictions.

The most disturbing minority view I have examined was written by Jane Orient, M.D. in the *Freeman* for last September. Dr. Orient is in the private practice of medicine in Tucson, and is also an associate in internal medicine at the University of Arizona College of Medicine.

Since her own specialty, ASIM, really initiated the movement that culminated in the RBRVS law, you may find her dissent intriguing, perhaps even scary. She comes on strong:

"As an internist, I . . . think that I deserve to be paid more. And I suspect that some of those others deserve to be paid less."

What bothers her is that the mechanism embraced by most of organized medicine, and now Congress, is pure Marxist central planning, as she sees it.

Whereas the American subjective theory of value considers the value of goods and services to the consumer, the objective theory of value "equates the value of a service with the cost of production . . . one of the fundamental tenets of Marxist economics." As an aside, she adds, "of course some of the costs — such as the estimate of 'stress' — (are) purely a pretense."

Noting that the Harvard researchers, in all their preparation for the study, "never interviewed a single patient," Dr. Orient finds it appalling that American physicians, however ill-rewarded they may consider themselves (as she does), have thus repudiated not only the fundamental American concept of consumer choice (subjective value) but have also turned their backs on what they should consider most precious: "In the subjective theory of value, the individual actor, the purchaser of goods and services, is the unit with which economics is concerned. In private medicine, *the individual patient with his own needs and values is the unit of practice.* [The emphasis is Dr. Orient's.]

"The ranking of values varies with each individual, depending on personal circumstances and expectations. A person may be willing to make great sacrifices to obtain certain services, but will purchase others only if they are very cheap. For example, to one person cancer chemotherapy or surgery may seem a burden so great that the expectation of benefit may not be worth the price (either in money or suffering). To another, a small chance of a cure may be worth any

amount of pain and all of his worldly possessions. No third person can make a determination of the value of the service, even though the cost to the persons providing it may be exactly the same in the two instances.

"According to the subjective theory of value, costs are basically opportunity costs incurred by the decision maker, i.e., the value of the other goods and services he is willing to forgo in order to obtain the goods and services under consideration. Such costs must be borne exclusively by the person making the decision; they cannot be shifted to others. Nor can they be measured by others. . . ."

Dr. Orient seems to believe the house of medicine has opened its doors to a Trojan Horse:

"The objective theory of value reduces both producer and consumer to interchangeable units in a collective. It is the stock in trade of the would-be central planners, who wish to control the practice of medicine, to standardize and depersonalize both medical services and patients. Hsiao sees the RBRVS as a mechanism by which (presumably omniscient) planners can redistribute physicians to areas of need and encourage or discourage certain types of practice behavior. . . .

"Forgotten in the debates in the corridors of power are two individuals who might be able to arrive at a price for services without the need for (an expensive) study; one doctor and one patient, making a voluntary agreement. . . . But the ability of individuals to make voluntary agreements is becoming ever more circumscribed in our welfare state, as the planners gain control of the resources.

"Like the leaders of the AARP and other lobbying groups, many persons today believe that the real relative worth of an individual doctor is not one cent more than the Harvard researchers calculate and the government pays."

What comes next after the objective theory of value is applied to physician services? Dr. Orient believes the same Marxist methodology, as she sees it, will be applied to rationing:

"How many deaths on the waiting list for heart surgery equal a year of hemodialysis? How many clinic visits for preventive medicine equal a cataract operation? And at what age does the cost-benefit ratio for a pacemaker exceed what 'society' is willing to pay?"

MASA is on record in support of the basic concept of an RBRVS to do justice to physicians who feel they have been discriminated against by historical charge structures, and I naturally support that position 100%. But Dr. Orient's argument, given added force by her own status as a potential beneficiary of such central planning, is certainly disquieting.

The more so because once you go to government for a remedy so radical as substituting the tender mercies of the federal government for individual choice,

you can't stop there. Government, by its nature, is forever expanding.

The decade of the 1980s ended with most of organized medicine supporting relative value. Will the decade of the 90s end with an agonizing reappraisal of that decision, after seeing it applied wholesale through the explicit rationing of care that seems to be coming?

I can only raise the question; I can't answer it. But I almost wish I hadn't read Dr. Orient's scholarly dissent from the position of her own specialty. □

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PRESIDENT'S PAGE



*Burt Taylor, M.D.
President, MASA*

We Can

Change, some great man said, is the only constant in life. Certainly the political activity in Eastern Europe will be a bright spot in the history of the free world forever.

With so many positive events exploding all around us, surely our world is a better and safer planet.

Hopefully, the environment in which we are practicing medicine will improve significantly.

As we enter a new calendar year, the daily commitment of the physicians of Alabama continues like a train on a track. The potential for calamity remains, but the train keeps on chugging through the long night, doing the best it can to deliver quality medical care in defiance of many possible bureaucratic derailments.

The challenge facing the medical community remains: deliver quality, 21st century medical care but at a lower cost. Unfortunately, some national leaders wantonly advocate medical cost containment at almost any cost, heedless of the damage to hospitals, physicians, or patients. Although we are entering a new decade, it seems to be the same old story. The possibility of significant positive change remains, but it is just that — a possibility. The need for constructive and prolonged dialogue between the physicians of America and the non-medical individuals who would like to control medicine is greater than ever.

As I review the letters received by MASA's Third Party Grievance Task Force, I am overwhelmed by evidence of how the "system" has mistreated so many

caring, honest, and dedicated physicians. The unnecessary work-load is compounding daily, while the frustration level is expanding exponentially.

The rude, unfair manner of communication sometimes disturbs me even more. Physicians explain how they have sent five or six letters trying to respond to a computer-dictated rejection of a \$50 charge. This continues over many months, until they either give up and write it off (as many carriers hope they will do) or they spend far more than the \$50 proving a point. The major abusive regulations are crippling many practices, but the nickel and dime disruptions are driving most of us crazy.

This past month I received a letter from an Alabama physician explaining how he has tried to keep going in spite of spiraling costs but steadily dwindling payment. He now realizes that he must close his practice. His practice consisted primarily of Medicaid and Medicare patients. He enclosed an audited financial statement for me to review. His situation was pitiful.

He asked for our assistance in trying to help other physicians with similar problems, as he realizes that his situation is beyond help. (He mentioned that earlier in his career he had raised several children and was compensated sufficiently to help each of them to obtain a degree.) The inadequate payments by Medicaid, along with the delayed and restricted payments from Medicare, were finally too much.

What a shame! Is this an isolated case or merely the

ominous tip of a potentially destructive iceberg? Can we really afford to wait and see? What is it going to take for physicians to finally say, "I have had enough," stand together, work within the system, and bring some reason and meaningful improvement in these unbelievable times?

An individual physician mailing strong and demanding letters or making blistering phone calls to an 800 number will not realize any long-term benefit. I believe the utilization of the Task Force will give each of us a pathway which will ensure that large and small problems will be brought to the attention of the appropriate decision-makers. This should guarantee some direct, responsive communication in return.

Through the Task Force, many problems will be resolved. Your Task Force is in place. We have already expanded our meeting hours and we will do whatever it takes to make this an effective forum for all physicians. The mood has been cooperative and positive. Your continued cooperation and support are vital.

First as your President-elect and then as your President, during 1989 I became acutely aware of the need for greater participation by more physicians throughout our state. It seemed to me that the best avenue would be to ask each of the well organized specialty societies to channel some of their energies through the State Association. I honestly believe they will receive far more than they will give. Therefore, during the spring and summer I spoke with most of the specialty societies during their annual meeting. I asked them to participate more actively through the State Association. Most of the specialty societies were very cooperative and pledged their support.

Representatives of each specialty society were asked to meet in Montgomery on January 13; I hoped for a significant representation and a positive meeting. Each society was to be given the opportunity to present its own views during this meeting. It is my belief that this beginning will lead to a stronger State Association and closer cooperation. It should strengthen our position with the legislature as we present a united force of 5,000 physicians.

Also, the concept envisions that any individual or small group of physicians having appropriate assistance readily available whenever necessary. Working with members of each specialty organization on a first-name basis should be beneficial to the leadership at the state level and vice versa.

As I have said before, our *potential* strength is significant. We desperately need state-wide unity, as the various divisive forces continually try to fragment the physicians of Alabama. In 1980 we were not very active politically but as we responded to the tremendous pressures and the impossible practice situations, we began to work together toward becoming a significant political force.

We were at least partially responsible for the election of many of the new faces throughout the state of Alabama. I believe the sky is the limit if we work within the system, represent our patients fairly and respond to the present crisis with openness and a willingness to make reasonable changes in the delivery of health care. We must lead in the health area and not simply fight, react, or be led.

We must continue to work in the political arena. Too many physicians feel they contributed money and time in 1985 and that should be sufficient for their entire career. We must work to ensure better conditions for the delivery of rural health care. We should assist our legislature in developing a means for expanding Medicaid eligibility. Each contiguous state has outstripped Alabama; we are not really moving forward in this area.

How many times have you attended a hospital staff or county society meeting with a certain mind-set based on hearsay or very little concrete information? After listening to various physicians state differing views, supporting their own points of view, and more importantly listening to your ideas, decisions are reached that are somewhere in the middle and really much better for all concerned.

This is the kind of forum we are hoping to create among the various physician groups in January. We have laid the groundwork. The State Association is ready to listen, provide needed input, and to do everything possible to make your life a little easier.

We plan to have a meeting of the specialty representatives each April, during the annual session, and each October. All Alabama physicians should be heard through their various representatives. We can determine the needs of any specialty group and try to put the shoulder of the entire Medical Association behind the appropriate wheel.

I am convinced that your State Association remains the appropriate vehicle through which so many problems can be resolved. The unknown problems of the 1990s are already out there, waiting their turn. They will pick the least opportune time and probably strike where we are most vulnerable. A solid, well-organized militia of minute-men (and women) must be ready to penetrate the many road-blocks that undoubtedly lie ahead.

Old Henry Ford was fond of saying: "The man who says I can and the man who says I can't are both right."

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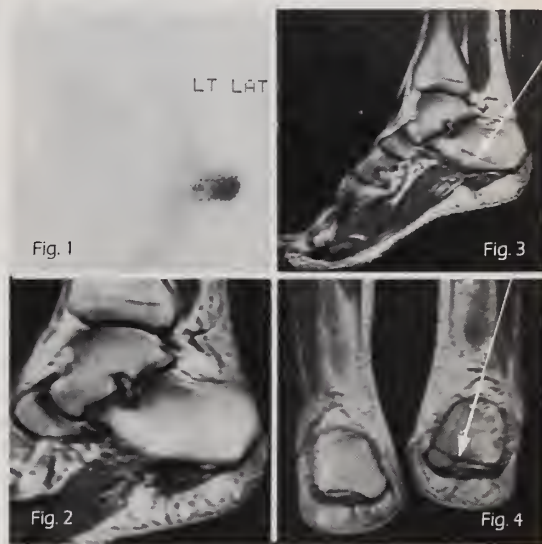
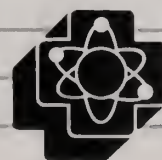


Fig. 1. Limited bone scintigram reveals abnormal tracer uptake in left calcaneus.
Fig. 2. Normal homogeneous signal intensity of marrow in right calcaneus.
Fig. 3 and 4. Sagittal and coronal (T2 [2000/30]) MRI images of left calcaneus reveal bands of signal void suggesting intraosseous fracture.



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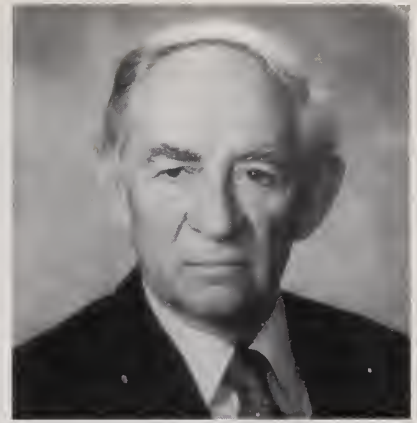
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Claude L. Brown, M.D.

Another House Call

Part II

[Continued from November 1989 *Alabama Medicine*]

"Dad, I want to go, you've let me go with you on some calls." I was clambering into the back seat after Pete. Dad answered impatiently, "All right, but you'll have to stay in the car."

We drove down Main Street, turned off into Jackson Lane, and pulled out of the sandy road onto the grass just after crossing the bridge over the creek. At one of the bends in the trail, where the bush didn't block the view, we could see legs — shoes, pants — even at that distance the bottoms of the pants looked tattered.

Dad and Pete were excited, and Dad forgot to make me stay in the car. We went past the pool where I had fished yesterday and then came to old Tom. Somehow he seemed shorter, as he lay all spraddled in the path. Dad knelt and felt for a pulse, then he gently placed the arm on the ground.

Pete, who hadn't gone too close to the inert form, asked, "He dead, Doc?"

Dad, still kneeling and now gazing around the spot, said, "Yep; been dead a while, too." He then examined Tom all over; I couldn't watch, and began to look around, at the trees, the bushes, the creek, anything. Something glittered in the weeds at the side of the path. I bent over and picked up Tom's knife.

"Look Dad."

Dad straightened up. "That his knife?" He took the knife from me and looked at it carefully. "No blood on it, clean." He was musing to himself, "... he

might have just had a stroke, or a heart attack, and fell dead. There's a big bruise on his head."

I asked, "How'd he get a bruise, falling here. There's nothing here that hard, to make a bruise. Just grass, and mud."

"And this," said Dad. He held out a rock, the size of a baseball. "He was laying over it."

Dad looked hard at Pete, whose mouth was still open. "Not many rocks down in the swamp, are there, Pete?"

Pete shook his head. Dad looked at him a minute longer, and then said, "O.K., Pete, you did good, coming to tell me. You stay here till we get back. Jed and I are going to see Martha." Seeing Pete shifting from one foot to the other, Dad said sternly, "Stay here, like I tell you. You're a grown man, aren't you?"

Dad and I walked for 15 minutes down the winding, faint trail before I saw the dilapidated shack on the border of a clearing. I had been thinking that I would never get to see Tom's squirrel trap, and that I would be the only kid that had ever been way down here to the Roundtree's place. But these thoughts were stopped by the sight of the chickens. For there were chickens walking on the tumbled-down front porch, and roosting on the window sills, and occasionally flying through the doorway. Dad stopped at the edge of the clearing opposite the house and called, "Martha, Martha, it's Dr. Martin." There was nothing to be heard, except the cackling of the chickens.

Instead of there being steps up to the porch there was a ramp made of old boards nailed on haphazardly,

with the ends all uneven, and the whole thing looking like it would blow away in a gust of wind.

We went up this to the porch. As Dad stepped gingerly into the doorway a big Rhode Island Red flapped squawking past his head. He said, "Damn," and we went in.

I just saw one room; it didn't look like a room in which people lived. My eyes, not yet accustomed to the shade inside the house, couldn't fully take in all the litter. But I saw a battered wood stove, with sticks of wood strewn around it, standing by a window, with a piece of stovepipe sticking through the window. Through the same window grew a branch of a fig tree that shaded the side of the house. Dad saw me looking at the tree limb and said, "Your mother says that fig trees grow near houses because they like to be close to people. That tree must feel mighty friendly." A filthy cotton mattress lay on the floor. Some pots and pans sat on the stove. And chickens sat, or walked, on everything.

Dad said loudly, "Martha, it's me, Dr. Martin. Martha, where are you?" There was a rustle of movement in a dark corner. As a form scuttled towards us I turned hastily towards the door. I thought it was some kind of animal, maybe a bear, or some nameless creature. Dad seized my arm. He said softly, "It's only Martha. You wanted to come, you know."

The form crawled over to Dad. A face looked up at him; she rubbed her head against his knee, like a dog. "She can't walk — just crawls around on her hands and knees. She's dumb, too. Just grunts. I guess she understands some of what you say to her, though. And she can sorta tell what's going on, if she knows you." He added, "course, she don't know anybody except Tom, and me. I guess that's all."

He bent down to her and touched her shoulder; she frantically skittered under the table. Then she crawled hesitatingly out again and glared at me. "Maybe she's just scared of you. But I've never seen her act like that before."

He spoke slowly and distinctly, "Tom is dead, Martha." She threw both arms around his legs and moaned. Her body jerked; her face was down on the floor. A chicken poked its head tentatively towards her.

"Tom is dead. We found him on the path. He won't be here any more."

She clutched Dad's legs tightly, and he stood there patting her shoulder. Suddenly she dragged herself over to the corner where she had been hiding when we entered. She came back to Dad and held a small snap-purse up to him. It was open, and there was nothing in it.

Dad said to me, "Tom kept his pension money in this. No telling how much he might have had, them living the way they do."

He rubbed his jaw thoughtfully, then asked Martha,

"Has somebody been here, last night, did somebody take your money?"

Martha's only response was to cling to his legs again. He shook her gently and talked soothingly to her, and asked her again, but he could get no indication from her that she understood him. He sighed, "Sometimes she's like that. I guess she gets just so much of what you say."

We left her then, and went back to where Tom's body and Pete were both resting; Dad thanked Pete and told him he could go. He went in a hurry, and Dad and I went home. Mother was wondering, of course, so Dad told her what had happened. She said, "Those poor old things. I guess she'll have to be taken to the county poor farm now. Or maybe we can find somebody who'd take her in and look after her. It is strange, though, Tom dying like that." Then with a woman's practical turn of mind she asked, "What are you going to say caused his death?"

Dad said, "I'll have to think about that," and left for his office.

I don't know what answer he would have finally come up with, but there wasn't any question about the cause of death when they found Ezra Jackson the next day. He was lying at the side of the lane, close to the bridge and he had been murdered.

Everyone had ideas, naturally. And everyone talked loud and long. Mr. Sloan said, "I bet there's an escaped convict hiding in the swamp."

Some people thought maybe Ezra's wife had killed him, since she didn't seem very sorry that he was dead, but I didn't believe *that*.

The sheriff, with all three deputies, came over from the county seat to investigate two deaths, one of which certainly was a murder, within a stone's throw of each other, was enough to bring everyone running.

When Dad got home that night I was full of questions, but Dad was busy with Sheriff Nicholson, who had accompanied Dad to our house.

"Now, Doc," the sheriff asked, "you and I have seen the wound on Jackson's head, a deep gash three inches long. It must have been made by a sharp instrument, heavy, with a kinda long cutting edge, right?"

"Right. It fractured the skull and damaged the underlying brain severely."

"Yeah, yeah, don't you think it's most likely one of those fellows down the road that did it? Tapped him in the head with an ax — been out cutting firewood — saw Jackson, drunk, easy pickings?"

"No," said Dad. "I know all those folks, and none of them would have done that."

The sheriff wasn't a man to let go of an idea, especially if it was his. He said, "From what I hear about Jackson, he could be mean. Maybe *he* attacked one of them boys. And maybe the guy was defending himself, even if it was self-defense, and good riddance,

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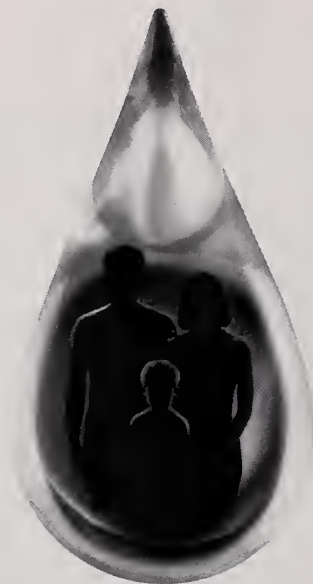


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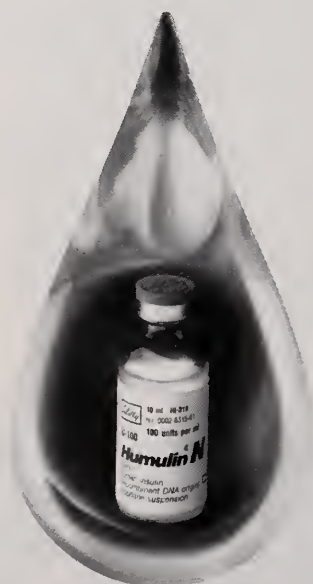
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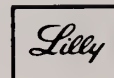


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that, maybe. But you know they're too scared to come up and say they done it."

Dad shook his head. The sheriff finished the coffee at Mother had brought him and said, "I'm going to talk to that fellow, Pete, some more. I'll be in touch with you."

So the town buzzed, and there were droves of people going down Jackson's Lane to where old Tom and Ezra had been found. I must have told my friends a hundred times about the Roundtree shack, with all the chickens, and the mess inside the place, and how old Martha looked. All the kids had been down the lane to the bridge, and even down the trail into the swamp ways, but they had been warned more strongly than ever about going there and none of them dared visit the shack.

The sheriff snooped around several days, questioning Ezra's widow, and the folks on the lane. He and Dad went to see Martha, but Dad said that she just hid in a corner and wouldn't do anything but grunt and tremble. The deputies, with eager volunteers, searched the lane and the adjoining swamp for the murder weapon but none was found. Sheriff Nicholson was still hot and heavy for wringing a confession from somebody, but he couldn't decide which one seemed more guilty than the others and he didn't really have anything solid on any of them. Dad told us at supper, Sheriff's gone back to Pickens. Says he'll be back and check some other angles. I suppose that's the end of the investigation, probably just as well."

The next Sunday the Baptist congregation decided at Martha must be provided another home. A family offered to take her, with Dad serving as guardian to pay for the board out of Tom's pension check. Dad arranged the details, and she was going to be moved the next day.

Late Sunday afternoon I eased out of the house and headed for Panther Creek. I didn't know why, but I had to go down in the swamp again. I knew as I took the trail off the lane that I had to go all the way down the path, all the way to Martha's shack.

There wasn't a soul on Jackson's Lane. I didn't know the exact place where Ezra's body had been found, but I thought that it wasn't far from the tree behind which he had been concealed, only a week ago. I kept looking around, even though I knew he was dead, and wouldn't be jumping out at me again. I crossed the bridge and struck off on the path. The weeds and bushes around the place where Tom had been lying were all trampled down; lots of curious people had visited this area during the past few days. Once past that little clearing, and beyond the pool in the creek, I began to get more scared. The swamp was always lonesome, and now, with a killer maybe somewhere close, the shadows deep back in the trees were even darker.

I thought of how old Tom had walked in this swamp, fast but quiet, and I tried to walk like that. Crackling in the underbrush occasionally made me jump, and twice I stopped, panting and feeling choked up, and almost started back home both times. "I've been to the cabin once, there's no one there but a poor old crippled woman," I reminded myself but it wasn't very reassuring. I tried to tell myself that I was down here seeking a clue, or looking for Tom's lost money, or something. But none of that helped and my heart thudded hard in my chest. The sight of a quick movement across the path paralyzed me until I recognized the tail of a black snake disappearing in the weeds.

Finally I heard chickens, even before I saw the roof of the shack. I flung myself down in the brush at the edge of the clearing. I was breathless from fast walking and fright. The shack, the yard, all were peaceful, silent in the sunlight.

Then there was a loud racket inside the shack; a chicken flew through the doorway and lit in the yard. Martha came crawling out on the porch. She must have been trying to catch that particular chicken, and she wanted it badly. For when she saw it out in the yard, she scuttled briskly down the ramp and went crawling on all fours after that chicken. I had stopped breathing. I could feel the hairs prickle on my neck. *For Marthas, as she scrambled at a good clip, was holding in her mouth the handle of a hatchet.*

She hadn't gotten close to the chicken when it became alarmed and ran off, flapping and squawking. As it passed the fig tree the chicken stopped to pick at something on the trunk. In that instant Martha reared back on her knees, her right hand plucked the hatchet from between her teeth, her arm went back and then whipped forward.

There was the glistening of sun on steel as the hatchet flashed fifteen yards across the clearing. There was a *whump* as the blade sank into the trunk of the fig tree. And there was the chicken's head, lying in the dirt, and there was the decapitated chicken flopping it its death throes.

Martha retrieved the hatchet, grabbed the now-still chicken and crawled back up the ramp and inside the shack. I ran. I ran all the way to Jackson's Lane. I ran, with branches slapping my face, with vines tripping me, with my chest about to burst.

When I got home I stayed in our shed until supper time. Mother said, as I sat down at the table, "You look like you're tired, Jed. You've been playing too hard. Your face is all scratched. You're going to bed right after we eat."

I was glad to do that, but in bed I didn't go to sleep for a long time. And then I had a nightmare. I saw that scene all over again, and that headless chicken flopped right onto me, and it was bleeding and its feet were kicking me, and I couldn't get away from it. . . .

I awakened with a jerk. In the dim light I saw Dad standing by my bed. He said softly, "Must have been having a bad dream, you were thrashing around."

I sat up. "Dad, I was dreaming that a chicken was kicking around on me; you know, a chicken with its head off." I had to tell him. I was afraid to because I knew that I wasn't supposed to have been in that swamp, but I figured I'd never sleep any more if I didn't tell him. I said, "Dad, I went down to Tom and Martha's place today, this afternoon. And I saw Martha chasing a chicken, and when she couldn't catch it, she threw a hatchet, and she can crawl real fast. . . ."

Dad looked at me quietly. "They kept those chickens for the eggs, and to eat, too. She can throw hatch-

ets, if she wants to. Old Tom could really heave that knife of his, too, I've seen him do it."

He rubbed his jaw, and said, "If she can hit a chicken I guess you're thinking that she can probably hit things bigger than that, eh? You and I know, that's good enough. Martha is going to have a home, and she won't have to throw hatchets at chickens."

He made me feel good; he usually did. I thought, as I drifted off to sleep, that the way he had talked sounded almost as if he had known what I was going to say. Maybe he had. □

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Lyme Disease

W. Foster Eich, M.D.*

Lyme disease is a "fashionable" disease these days. It has even made the cover of *Newsweek*!¹ However, relatively few cases have been reported in Alabama.² The purpose of this paper is to review the disease briefly in order to alert Alabama physicians to it.

Lyme disease was first described in Lyme, Connecticut, by Dr. Allen Steere, a rheumatologist who was impressed by the fact that there was an unusual cluster of cases of juvenile rheumatoid arthritis in the same small town.¹ As he studied the cases, he found that they were not typical of JRA but had distinctive features which characterized another disease; the disease has come to be called by the name of the town, Lyme disease.

The patient with Lyme disease typically presents with fever. Indeed, without the characteristic rash or arthritis the disease would appear to be a non-specific febrile illness. Fever may last as long as two weeks before the onset of arthritis.

However, 60% to 100% of patients have arthritis or arthralgia during the course of the illness.^{3,4} The arthritis usually affects the large joints, such as hips or knees; sometimes small joints of the hands and feet may be affected. The arthritis is oligoarticular; as many as four joints may be involved. Lyme disease can be indistinguishable from septic arthritis. Usually knee (41 cases), elbow (8), hip or ankle (5), and shoulder, sternoclavicular or interphalangeal joints (1 each). Usually there is articular swelling or tenderness. Erythema is rare. The arthritis resolves in 60% of cases within 1 week, but persists for months in 15%.

Fever is present in at least 50% of cases. Only 45% have a history of tick bite, for reasons that will be mentioned later. About 40% have the typical rash, erythema chronicum migrans.³ Central nervous system symptoms are not rare: Stiff neck, headache, VII nerve palsy, other cranial nerve neuropathies,⁶ or iritis³ can also occur. Heart block can occur, and has been fatal.⁵

The characteristic rash is erythema chronicum migrans.⁵ It is a circular rash, which gradually enlarges. There is central clearing. The rash may be present at the site of the tick bite, but it may also be present at other places. When the rash is seen, it is pathogno-

monic. A dermatologist tells me that he has seen several cases of the rash which were so early that there were no other symptoms, and the serology was still negative. He recommends treating those cases, since fatal heart block may be the next clinical manifestation.⁷

The only consistently abnormal laboratory finding is elevated sedimentation rate.⁴ Usually there is a leukocytosis with a left shift. Serologies may not be positive until the second week of illness.

Neurological abnormalities include meningitis (aseptic), encephalitis, cranial neuritis (especially VII, but also V, VIII, III), usually transient; myelitis, hemiparesis, ataxia, chorea, or Guillain-Barre syndrome. Probably all cases of Bell's palsy should be tested for Lyme disease; facial nerve palsy is a fairly common complication.⁶

A curious feature of the disease is that it has been present in Europe for a long time, but usually produces neurological rather than joint disease. Apparently the European strain of *B. burgdorferi* causes neurological disease much more commonly than arthritis.⁵

The disease can produce cardiac abnormalities. It does not produce valve disease, but can produce conduction defects (i.e. heart block) and these have been fatal.⁵

The diagnosis is confirmed by serology. A VDRL should always be run as a control; syphilis can give a false-positive test for Lyme disease. But the serology may be negative until the second week of illness in as many as 50% of patients.⁵

Lyme disease is transmitted by the bite of Ixodid ticks. The vector in New England is the deer tick, *Ixodes dammini*. This tick goes through a complicated life cycle. During the early stages of the summer, while the tick is very tiny, it prefers rodents (specifically the white-footed mouse) as a host. During mid-summer, while in an intermediate stage of development, the tick prefers medium sized animals; dogs, cats, racoons, and man.¹ During the late summer and fall the tick prefers large animals — deer or bear — as its host. Even at its largest, it is only one to two millimeters long. And when it bites man, it is often half that size. For that reason, many patients do not recall a tick bite.

I. dammini is said not to occur in Alabama, and it

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is as yet unknown what tick is the vector. *Ixodes scapularis* is said to be the vector in Georgia.²

In any event, *Ixodes* ticks have been found on migrating birds, so they can be transported to new areas and presumably become indigenous there.⁵

The main reservoir of Lyme disease infection is probably the mouse. Dogs and cats can also be infected; the diagnosis has been suggested to a family by the family veterinarian, who diagnosed Lyme disease in the family dog!⁵ The disease is not spread by eating deer meat.

The spirochete is sensitive to penicillin and tetracycline. If the patient with Lyme disease is over 8 years old, the drug of choice is probably a tetracycline. For children under 8 years old, penicillin is recommended. Erythromycin can also be used for a patient allergic to the above. The disease is a spirochetal infection, and (as with syphilis) a Jarisch-Herxheimer reaction can occur when treatment is begun.⁵

In cases of chronic Lyme disease, prolonged treatment with intravenous penicillin has been recommended. Ceftriaxone intravenously has also been useful in these cases.

Although Lyme disease is caused by a spirochete, there is no evidence of sexual transmission. There is evidence that the disease can be transmitted to the fetus during pregnancy, however.⁸ Some women who were infected with the spirochete during pregnancy have had fetal deaths; others have borne infants with multiple congenital anomalies. Probably all pregnant women with tick bites should be treated with penicillin; if a pregnant woman is known to have Lyme disease, she should probably be treated with high doses of penicillin parenterally.

In summary, Lyme disease is a protean disease capable of manifesting itself in almost any system of the body. Any physician may see a case, regardless of specialty. It should always be considered in the differential diagnosis of a vague, febrile illness. Since the rash or arthritis may not be present or may be atypical, and the serology may not be positive until late in the disease, diagnosis may depend on a high level of awareness. It is treatable, but successful treatment is much easier early in the course of the disease. □

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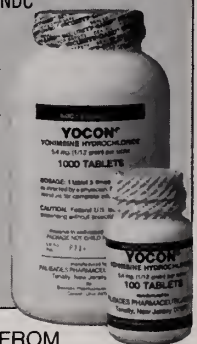
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Possible Lyme Meningitis

Mark D. Kelley, M.D.*

Lyme disease was first recognized in 1975 because of a cluster of patients with arthritis in the vicinity of Lyme, Connecticut. Subsequently the arthritis was linked with erythema chronicum migrans (88%), cardiac (8%), and nervous system diseases (11%).^{1, 2} By 1983, the etiology of the disease had been confirmed as an infection caused by a spirochete, *Borrelia burgdorferi*,³ transmitted to man by the bite of a tick, *Ixodes dammini*. Then it became apparent that this was the same disease reported as far back as the 1920's, known in Europe as tick-borne meningeal polyneuritis, lymphocytic meningoradiculitis, or Bannwarth's syndrome.⁴

The usual presentation includes exposure to ticks or tick-infested areas of the Northeast, the characteristic rash, and then the neurological abnormalities, then the arthritis. This case is presented to illustrate the possible presence of the disease with no history of tick exposure, no travel to areas usually considered endemic and no characteristic rash.

Case Reports

A 32-year-old black female was in excellent health until three days prior to admission when she developed occipital headache, fever, chills, right-side face pain and right-sided sore throat. She denied travel outside of Tuscaloosa County within the last six months;

tick bites or exposure to tick-infested areas or animals. She kept a pet cat, mostly outside. She specifically denied any history of rash or arthralgias.

On exam she appeared moderately ill, temperature 103.2°F (39.6°C), heart rate 112. Her neck was not stiff, but there was pain on flexion. There were no skin lesions except for miliaria on the anterior chest. Neurological examination was normal, except for paresthesias in the distribution of the right trigeminal nerve.

Her white blood count was 8,400, 84% neutrophils, 9% lymphocytes, 5% monocytes. Chemistry profile was normal, except for an SGOT of 73 (normal 4-29) and LDH of 237 (normal 100-190), GGTP 161 (5-55). [There is a question of previous excess use of alcohol.]

Spinal fluid on admission showed a white count of 22 (11% neutrophils, 89% lymphocytes), protein 42, glucose 68. Spinal fluid on day #8 showed a white count of 214 (4% neutrophils, 76% lymphocytes) protein 106, glucose 73. Simultaneous blood glucose 125.

Sedimentation rate was 102mm/hour. Urinalysis showed 2+ protein.

Multiple cultures of blood, spinal fluid, throat, and cervix were all negative. The following serological tests were also negative: VDRL, rubella, herpes I, toxoplasmosis, leptospirosis, antinuclear antibody, cryptococcosis, mononucleosis, and Human Immunodeficiency Virus. Spinal fluid stains for acid fast bacilli and India ink preparation were negative. Skin test for tuberculosis was negative and the control was positive. Computed tomography scan of the head showed no brain abscess and no sinusitis. Electrocardiogram showed a PR interval of .16 seconds.

In the emergency room, the patient was started on ceftriaxone 1 gram every 12 hours. This was discontinued 48 hours later when all cultures were reported

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as negative. Her right facial parasthesias resolved in 24 hours. Her headache and fever of 102°F (38.8°C) to 103°F (39.4°C) persisted for eight days in the hospital (and three days prior, for a total of 11 days). The patient remained afebrile and asymptomatic for the next four weeks with no treatment. Even though she remained asymptomatic, she was subsequently given a course of tetracycline, 500 milligrams four times per day for one month.

A serum titer (combined IgG and IgM) for Lyme disease was 1:256, drawn on the 21st day of the illness. Three weeks later the titer was less than 1:256.

Discussion

The unusual features of this patient's "aseptic meningitis" included the paresthesias of the right forehead, and the duration of her fever. Careful daily review of her history was consistently negative for exposure to dogs, ticks, wooded areas, etc. A pet cat has recently been reported as a risk factor for Lyme Disease.⁵

In the endemic region of Connecticut there have been at least 15 patients reported with meningo-encephalitis and cranial neuritis associated with Lyme-disease-antibody titers of 256 or greater, with no history of erythema chronicum migrans and only one recalled a tick bite.⁶ In these cases the diagnosis was assumed correct because control groups in endemic areas, even with neurological and rheumatic diseases, seldom have antibody titers greater than 1 to 40. "Thus, a positive result (titer of 1:128 or more), even in a single serum specimen, in a patient with neurologic involvement is strong evidence for the diagnosis."⁷

Of patients with erythema chronicum migrans, only 20-30% recall a tick bite. From 1975 until the present, the disease has been recognized all over the Northeast and now in Wisconsin, Minnesota, California, Arkansas, North Carolina, Texas, Florida, Georgia, Virginia, Tennessee, and Alabama.

Since this disease is easily treated with antibiotics, it is important to maintain a high level of consciousness and a low threshold for ordering the Lyme disease antibody titer.

The antibody titer may be low at the onset of erythema chronicum migrans, but the rash is so characteristic that treatment with tetracycline 250 milligrams four times a day for ten days should be undertaken without waiting for the results of the blood test.

Aseptic meningitis associated with a cranial neuritis following a tick bite or a history of an annular rash should be started on 20,000,000 units of intravenous penicillin daily⁸ or ceftriaxone 2 grams daily for 14 days without waiting for the blood test. Isolated neurological symptoms (such as Bell's palsy) may be treated with oral tetracycline for one month.⁹

Cases of aseptic meningitis, even with no unusual features and no history of rash or tick bite, probably

should have the blood test for antibody to Lyme disease ordered so that appropriate antibiotic therapy can be instituted later if the test is positive. Even if the patient has recovered completely by the time the blood test is reported, there may be benefit in treatment. The meningitis and neuritis of Lyme disease is often recurrent and the arthritis can follow the neurological syndrome by several months. The arthritis and neuritis are probably immune reactions caused by persistence of living spirochetes and delayed treatment with antibiotics has been shown useful.¹⁰

Aseptic meningitis even with no history of tick bite and no rash could also be Rocky Mountain Spotted Fever.¹¹ A delay in diagnosis and treatment with tetracycline may be fatal. The antibody test for Lyme disease is not 100% sensitive or specific. When the prevalence or probability of the disease is low, as with the patient reported here, the predictive value of a positive test may be only 50%, but the prevalence will remain uncertain unless this disease is considered and tested for more often.

Summary

Aseptic meningitis may be Lyme disease, even in Alabama, even with no history of tick bite and no history of rash. Aseptic meningitis is a late development in the course of the disease, the antibody titer should be positive at the onset of neurological symptoms. Since specific antibiotic treatment is helpful, the antibody test should be done in any case of aseptic meningitis that seems slightly prolonged or is associated with neuritis. Even cranial neuritis alone, such as Bell's palsy, should warrant the blood test.

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LEGIONELLA LONGBEACHAE

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The clinical spectrum of illness associated with Legionella infection has expanded dramatically since the famous outbreak of pneumonia in Philadelphia in 1976 to include an influenza-like illness, nosocomial pneumonia, pneumonia in the immunocompromised host and prominent extrapulmonary involvement.¹ So too has the number of *Legionella* species causing infection in humans increased and currently numbers 18.² One of the recently described species, *L. longbeachae*, has been isolated previously from only six patients³⁻⁵ and diagnosed serologically in another patient.⁶ We present the first description of pneumonia due to *L. longbeachae* in a patient who resided in Alabama.

Case Report

A 66-year-old man with diabetes mellitus was admitted to the hospital with a two-week history of weakness and a one-week history of chills, dyspnea, cough and hemoptysis. The patient was treated for pneumonia as an outpatient one-year prior to admission and had resided in Alabama all of his life. On physical examination the temperature was 101.4 F and the respiratory rate was 32/min. He was using accessory muscles of respiration and bilateral rales and rhonchi were audible. The leukocyte count was 15,200/cu mm and arterial blood gas determination revealed hypoxemia with a PaO₂ of 52 torr. There was elevation of the serum creatinine to 3.1 mg % and liver function tests were approximately double the normal values. Chest x-ray film showed bilateral diffuse interstitial and alveolar infiltrates. Blood cultures were sterile and sputum culture grew normal flora. Treatment with intravenous cefotaxime sodium, 6 gm/day, was started and the patient received mechanical ventilation.

Four days after admission an open lung biopsy was performed because of progressive pulmonary deterioration. Grossly the lung demonstrated confluent consolidation and microscopically an acute necrotizing pneumonia with early organization was detected. Special stains for acid-fast bacilli and fungi were negative. Culture of the biopsy specimen on charcoal yeast

extract media grew a pure growth of *L. longbeachae* (identified by the Centers for Disease Control, Atlanta, GA).

Postoperatively the patient was placed on intravenous erythromycin lactobionate, 2 gm/day, and imipenem-cilastatin, 2 gm/day, and gradually improved. He was released from the hospital 23 days after admission and has not suffered another episode of pneumonia in over two years following discharge.

Discussion

Common to all *Legionella* species, *L. longbeachae* grows on buffered charcoal yeast extract media, fails to grow on blood agar, requires cysteine for growth and is gram-negative on Gram stain. It is differentiated from *L. pneumophila*, the etiologic agent of Legionnaires' disease, by its inability to hydrolyze hippurate and from other *Legionella* species by direct fluorescent antibody staining.² In vitro susceptibility studies indicate that *L. longbeachae* is less susceptible to erythromycin and rifampin as compared to *L. pneumophila*³ and the mortality rate of the seven patients with *L. longbeachae* pneumonia treated with erythromycin was 57%.³⁻⁶

Thus far, all cases of *L. longbeachae* infection have been community-acquired and usually involved immunocompetent hosts. All patients demonstrated pneumonia occasionally with abscess formation and pleural effusion and four cases required mechanical ventilation. Extrapulmonary manifestations consisting of pancreatitis, renal microabscesses, renal failure and disseminated intravascular coagulation were seen in four patients.³⁻⁶ Similar to previous cases, our patient had pneumonia, was immunocompetent, needed mechanical ventilation and displayed extrapulmonary findings comprising abnormal renal and hepatic laboratory values.

In summary, we have described the first case of *L. longbeachae* pneumonia in an Alabama resident.

Acknowledgement

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The Retirement Plan Distribution Decision

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No matter how diligently you have worked and set money aside for your retirement years, there is no escaping the complex tax rules governing qualified retirement plan distributions. If you have participated in such plans, it is vital that you make a well-informed decision about the most efficient means of taking plan distributions. An incorrect decision could cost you thousands of dollars in unnecessary taxes.

To more fully understand the complexity of this issue consider the following questions:

- If a lump-sum settlement option from your pension plan is available, should you elect it? If yes, should you roll over the distribution into an Individual Retirement Account (IRA)?
- If you choose to receive a lump sum distribution, what are the tax effects of electing ten year forward averaging? What about five year forward averaging?
- Are you eligible to elect the Special Capital Gains Tax Treatment? If yes, what would be the effect on your taxes?

Given the complexity of current tax laws and your unique personal and financial responsibilities and goals, these are not easy questions to answer. However the correct answers can greatly increase your net after-tax benefits from your qualified retirement plan(s). The first step to take to simplify your retirement plan decision-making is to gain an understanding of the following key terms.

1. Qualified retirement plans allow assets to accumulate on a tax deferred basis through a program

established by the employer — including self-employed individuals and corporations. Among the more common types of qualified retirement plans are pension plans, profit sharing plans, and 401(k) plans.

2. For a retirement plan distribution to qualify as a "lump sum," you must receive the entire balance of your plan within one tax year. It is not necessary, however, to receive the entire balance in a single payment.

3. Ten year forward averaging describes a method of figuring the amount of taxes that might have been paid if your lump sum distribution had been spread over ten years, as opposed to over a single year. Only individuals who were at least 50 years old as of January 1, 1986 may elect ten year forward averaging. When deciding whether to choose this option, consider that if you do so, the tax rates that were in effect in 1986 must be used.

4. Five year forward averaging assumes the lump sum had been spread over a period of five years. If you were not yet 50 years old as of January 1, 1986, you must wait until you turn 59½ before using five year forward averaging. Current tax rates are used.

5. The special capital gains tax treatment permits the portion of your lump sum distribution representing pre-1974 years of plan participation to be taxed at long-term capital gains rates — 20%. This option can only be elected by plan participants who were at least 50 years old on January 1, 1986. It is available only through 1991. For all others, the Tax Reform Act of 1986 phased out long-term capital gains benefits.

If you receive a lump sum distribution and do not elect forward averaging, ordinary income taxes will be due on the entire sum. However, once ten year or five year forward averaging is chosen, you cannot use either option again should you receive another lump sum distribution from your retirement plan(s). You may also elect to roll all or a portion of your retirement plan assets over to an IRA. This choice permits the assets rolled over to continue to accumulate on a tax deferred basis until distributions are taken.

Most qualified plans also provide the option of withdrawing your assets in the form of an annuity. An annuity is a contract with an insurance company which

provides a series of periodic payments scheduled to last over some time period. The more common types of annuities include a straight life annuity which provides a stream of payments throughout your lifetime. A joint and survivor annuity provides payments until both you and your beneficiary die. The payments of a term certain annuity cover a specified number of years. Annuities payments are taxed as ordinary income in the year they are received.

To help you choose between the available options, compute the amount of taxes you would have to pay using both ten year and five year forward averaging. Then compare these results with the amount you would pay in taxes if you rolled over your assets to an IRA and began drawing the money out at a later date. An additional consideration to factor into the decision-making process is the question of whether tax rates will remain at their current levels over the next few years. Higher future tax rates would lessen the attractiveness of rolling your distribution over to an IRA — even if you do not need the income at present.

Retirement Plan Dateline

In addition to gaining an understanding of the distribution options available to you, keep in mind several important retirement planning dates. With the exception of plan participants who die, become disabled, or elect to take out their money in substantially equal annual payments over their expected lifetimes, participants cannot receive plan distributions prior to the age

of 59½ without paying a 10% penalty to the Internal Revenue Service (IRS). Ordinary income taxes must also be paid on such distributions.

A limit also exists as to how long you can delay taking money from your retirement plan. Participants, even if they have not yet retired, must begin receiving distributions no later than April 1 of the year after they turn 70½. The amount distributed each year must be in compliance with the minimum amount mandated by the IRS.

IRS distribution minimums are determined by the market value of your plan and a life expectancy factor. The trustee of your retirement plan should be able to tell you the minimum amount to take each year. If in any given year your distribution is less than the amount required by the IRS, you will have to pay a 50% excise tax on the difference between the required minimum and the actual amount distributed. The potential exists for plan disqualification if minimums are not met. However, if your distributions are being taken in the form of a lifetime annuity or a joint and survivor annuity with the spouse as beneficiary, this requirement is automatically satisfied.

For more detailed explanations about this complex subject and for assistance in computing the tax effects of ten year and five year forward averaging, you should consult your tax advisor or accountant. A well-informed decision about your retirement plan distribution options will form the cornerstone of a financially secure future for you and your family. □

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Space Station Technology Applied to Clinical Care

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The Consortium for Space Life Sciences (CSLS), begun at the University of Alabama in Huntsville in November 1987, is a cooperative association of organizations in academic and private industry with interest in development and support of the life sciences in space and on other planets. One current, exciting area of interest is in developing and implementing life support technology for the Space Station Freedom. Space Station Freedom represents this nation's first attempt at providing recycled air and water to support man for a prolonged time period in space. Recycling of air, water, and, eventually food are key enabling technologies for the next great stage of manned space exploration, the investigation and eventual colonization of our solar system. All previous efforts, including the Soviet space station Mir, have included regular fresh water resupplies from earth. The cost of this resupply, estimated by some to be almost half the cost-weight of every resupply ship payload, would be prohibitive for the current U.S. effort.

Therefore, to make manned space ventures cost effective, the crew must be able to use reclaimed and recycled water. The problems inherent in the design of a system to reclaim and purify urine and water from shower and other hygiene sources challenge today's technology.¹ In addition, such systems have important potential for addressing rapidly escalating water use and pollution problems on our own spaceship Earth. The Consortium brings together engineers, physicians, biologists, chemists and toxicologists necessary to address the complexities of designing such life support systems for today and the future.²

Historically such efforts have directly resulted in important biomedical "spinoffs."^{3,4} The list of devices developed in part with NASA support includes pacemakers, portable defibrillators, precise remote drug delivery devices, telemetry, and implantable automatic defibrillators, to name just a few. The CSLS has identified near real-time medical monitoring as one important spin-off of the Freedom Station life support system design effort. An example of real-time monitoring now in widespread use is transcutaneous oxygen measurement. The considerable convenience and efficiency of this technology compared with repeated arterial blood gases has demonstrated to many clinicians the value of such a technology development effort.

On Space Station Freedom, considerable attention will need to be paid to detecting the presence of recycled water contamination. Special emphasis will be on traditional water pathogens as well as environmental bacteria with minimal nutritional requirements which are capable of surviving wide temperature variations. Recent experience on Earth with *Legionella* infection and resistance to decontamination has demonstrated the significance of this problem.^{5,6} Maintaining a constant water surveillance system in orbit using traditional culture methods, however, would be extremely difficult due to logistics and the amount of crew time that would be necessary. In addition, a delay of several days in recognizing a major contamination of the water supply could be disastrous for the crew or lead to long-term fouling of the life support system.

Seeking Candidate Technology

Consortium members, with funding from NASA's Office of Aeronautical and Space Technology, recently began to define a workable real-time microbial monitor (RTMM) for use on Freedom Station. This

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project is monitored by NASA's Johnson Space Center. Under this effort, criteria have been established for assessment of current and developing methodologies. Candidate instruments must be lightweight, small, very power efficient, sensitive, precise, and capable of functioning in microgravity. They must provide information very quickly, require very little crew manipulation, provide some samples for later subculturing and produce no toxic by-products. These requirements and other technical criteria were applied to 28 leading candidate technologies. Table 1 shows the top 11 technologies evaluated using a scoring system based on these criteria.

Ultimately, RTMM will probably use a combination of these methods, with fluorescent technologies being of principal importance. Primary fluorescence (Figure 1) is a natural phenomenon which occurs in some molecules when, following exposure to light, the molecules later emit captured light energy at a different wavelength. This decay function phenomenon is characteristic of a given compound at a given wavelength, thus providing a time-resolved "signature." Indirect indicators of biomass, such as NAD or NADP, can be measured in a very short period of time using primary fluorescence. Secondary fluorescence amplifies this effect by adding another substance, a fluorophore, to the sample to increase resolution. When combined with a direct technique such as laser light scattering, which produces an actual count of both cells and inanimate particles, this combination technology provides a powerful mechanism for monitoring water quality.

Biomedical Application

As an example of how such a space-initiated effort can have a positive impact on Earth-based medical care, we chose to focus on the current approach to the patient at risk for bloodstream infection. Our premise was that if bacteremia could be detected in near real-time, an entirely different clinical strategy would be

TABLE 1
Summary of the Technical Evaluation

Description	Points Total*
Laser Light Scattering	192
Electronic Particle Counting	186
Primary Fluorescence	174
Secondary Fluorescence	142
Volatile Product/MF	136
Bioluminescence	114
Direct Viable Count	113
Membrane Filtration	112
Chemiluminescence	110
Epifluorescence	109
Electron Microscopy	100

*Maximum Available Points = 224

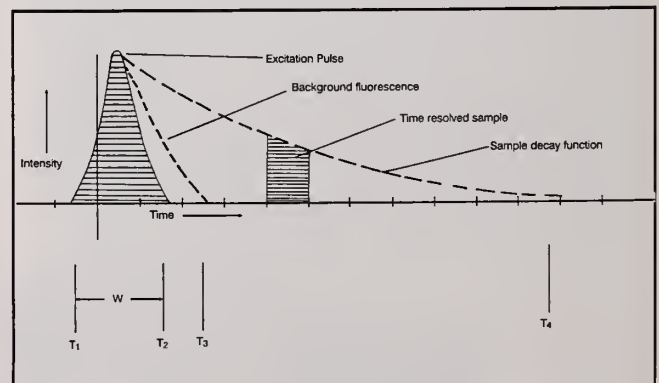
TABLE 2
Parameters of Formed
Elements in Blood

	Size	Concentration
Leukocytes	15 microns	10 ⁶ /ml
Erythrocytes	7 microns	10 ⁹ /ml
Platelets	3 microns	10 ⁸ /ml
<i>Clostridia</i> sp.	4 microns	10 ² /ml
<i>E. coli</i>	3 microns	10 ² /ml
<i>Staphylococcus</i> sp.	1 micron	10 ³ /ml

possible. Figure 2 shows the method for detecting infections of the bloodstream that was common until very recently, and is still used in many hospitals. After an initial period of growth, 65% of positive cultures could be detected by inspection for turbidity or hemolysis, and subsequent gram stain and subcultures would provide precise identification to the species level. This level of gross detection requires 10⁷ organisms per ml, a very high density.⁷ Blind gram stains may detect another 23%, and require a 10⁵/ml density. Blind subculture identifies another 12%, but may require a two-step growth process that could take as long as four days.⁸ Unusual or fastidious organisms may take several more days to recover or identify reliably.

Figure 3 shows a second generation method available in many hospitals which is based on CO₂ detection.⁷ As growing organisms, bacteria produce increasing levels of CO₂ as a metabolic by-product, which can be detected as radio-labeled carbon is released. Newer machines also detect CO₂ directly, without the need for radioactive materials. Theoretically, these machines should allow for continuous measurement of growth, but the practicalities of the conveyor belt system dictate that only periodic measurements are possible. When a detection threshold is reached, a gram stain and subsequent subculture can precisely identify the organism(s). While staphylococci and some gram-negative organisms can sometimes reach the threshold in 12 hours, studies with the newer machines continue to show a mean time to detection of 31 hours.⁹

Figure 1.



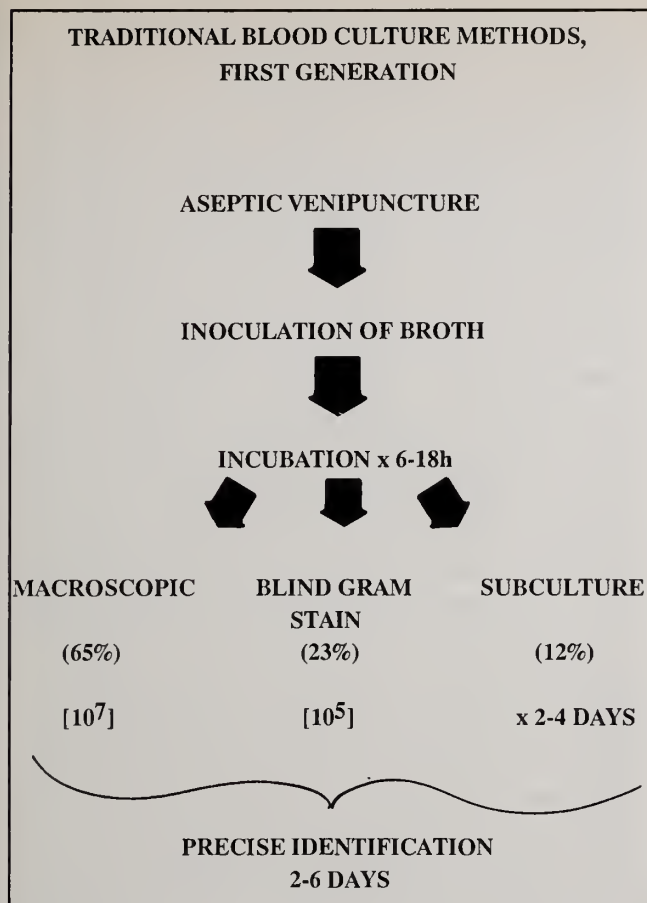


Figure 2.

This delay in precise determination of bacteremia has resulted in the common practice of the "three day rule-out" approach to the medical management of sepsis. Thus, the patient receives 48 to 72 hours of expensive and relatively invasive antibiotic treatment in the hospital while the clinician awaits the culture results. This approach has been modified only slightly by rapid antigen tests of the urine or cerebrospinal fluid (CSF), partially because they are reliable for only a few species and the false negative rates are too high. This management has been altered by the recent development of broad spectrum antibiotics that show remarkably low rates of emergence of resistant organisms. Currently, in most bacteremias, the clinician is less concerned with antibiotic sensitivity patterns of the organism than in simply determining the presence of bacteremia and the differentiation from skin contaminants. Persistent bacteremias, such as endocarditis, are viewed differently. Particularly elegant quantitative methods for organism identification and determination of antibiotic sensitivities are appropriate in this situation.

Technical Challenges

The application of technology for real-time microbial monitoring of water to the clinical problem of

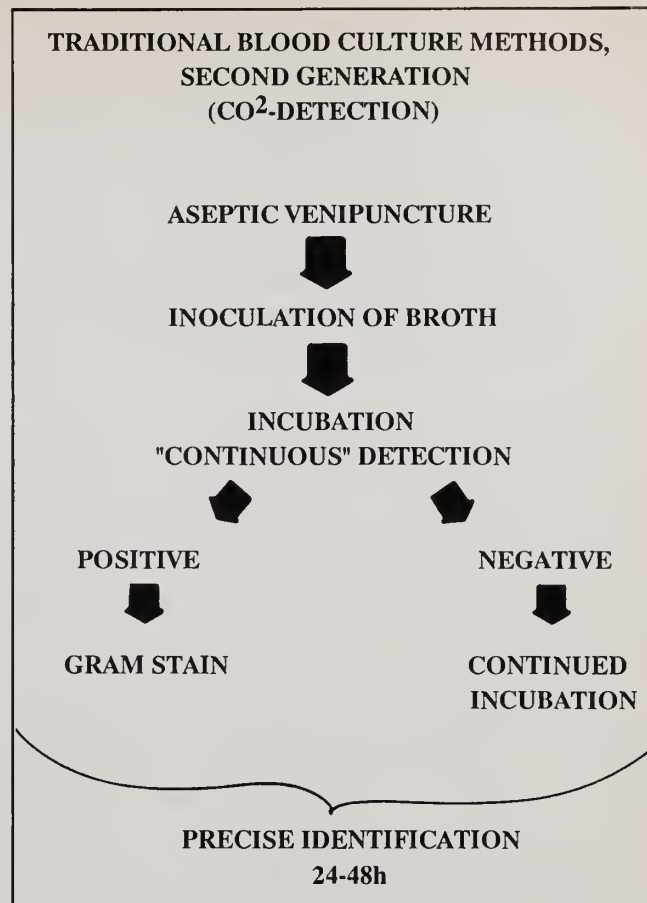


Figure 3.

bloodstream infection presents a new set of challenges. Blood is not a homogeneous medium with only small amounts of suspended particulate matter, as is the case with relatively clean water. Table 2 shows the major formed elements of the blood as they compare in size and concentration to microorganisms.

Platelets will provide the greatest problem with any counting mechanism, given the overlap of size and high concentration. In addition, any fluorescent measure of biomass will detect compounds in solution, such as aromatic amino acids like phenylalanine and tyrosine, and small amounts of free hemoglobin and other serum proteins. Although very precise wavelength "gating" could probably decrease the background noise, specificity would probably drop below clinically acceptable levels.

For this reason, a short growth phase could be used as a mechanism to increase resolution. If a time resolved sample intensity at time zero were subtracted from the same wavelength intensity at 60-90 minutes later, the biomass increment would represent growing and multiplying cells. This would differentiate viable bacteria from dead cells or formed blood elements. In addition, calibration would be necessary for the "background" bacteremia that occurs from daily activities, such as toothbrushing.

The Newborn at Risk for Sepsis

If near real-time microbial monitoring of bloodstream infection were available to physicians, the management strategies used in a number of clinical situations could be modified. The first pertinent clinical situation is the potentially infected newborn, born in the setting of prolonged rupture of membranes or frank amnionitis, heralded by fetal tachycardia, maternal fever and uterine tenderness. Previous experience with overwhelming sepsis and death (often from group B streptococcal infection) with a minimum of warning clinical signs has led to a very aggressive therapeutic approach to these babies. Although initial laboratory evaluation with leukocyte ratios and C-reactive protein determinations may be used in making decisions, the mainstay of management is presumptive treatment.¹⁰ Blood cultures, and in some cases CSF and suprapubic urine cultures, are done and the infant is committed to 48-72 hours of intravenous antibiotics administered every 6 hours.

While the majority of these babies tolerate this treatment well and this strategy is justified to prevent the occasional case of lethal sepsis without warning, it has significant financial and emotional costs. It requires that IV access be maintained, making it physically cumbersome to cuddle the newborn normally. Some kind of special nursing care is required, necessitating a higher daily charge for a "special care nursery" in many hospitals. The cost of frequently administered antibiotics is extremely high, and can amount to several hundred dollars per day. In addition, any planned early discharge must be delayed, usually necessitating the mother's longer stay on the postpartum unit with those attendant costs.

The emotional costs of the "three day rule-out" cannot be quantified. Clearly, the celebration of a new

life is dampened by the necessary careful observation of the infant during the first 12-18 hours, and it is difficult to hide the extra vigilance of the care-givers and the unspoken message that "this is not a well baby." The bonding process is at least a feeling in the parents that their baby is okay. Experienced clinicians recognize the look of anxiety on parents' faces when at the end of the "rule-out" period the baby is certified well and sent home a few minutes after the IV is removed.

Figure 4 shows the difference in strategy that would be possible if reliable near real-time methods for assessing bloodstream infections were available. In this case, in all but the highest risk infants, only a single intramuscular injection of antibiotic would be necessary while waiting the 1-2 hours required for the determination. By the time the newborn infant had come out of the normal "sleepy" stage that begins 15-30 minutes after birth, the issue would be resolved. While the issue of CSF or urinary infection would have to be dealt with separately using current technology, the absence of bacteremia would most likely prove to identify the low risk infant reliably. This "science fiction" technology would require extensive clinical validation to prove an extremely low false negative rate, but the development costs would be well spent. A first order approximation reveals that at a savings of approximately \$1300 per baby, the new technology would save over \$8 million in Alabama in a single year, in addition to potentially decreasing parental anxiety.

The Elderly Patient at Risk for Sepsis

At the other end of the spectrum is the elderly nursing home patient who has a fever and altered mental status. While there are generally more warning signs of impending death in this situation than in the newborn, many of the issues are the same. Elderly patients,

Figure 4.

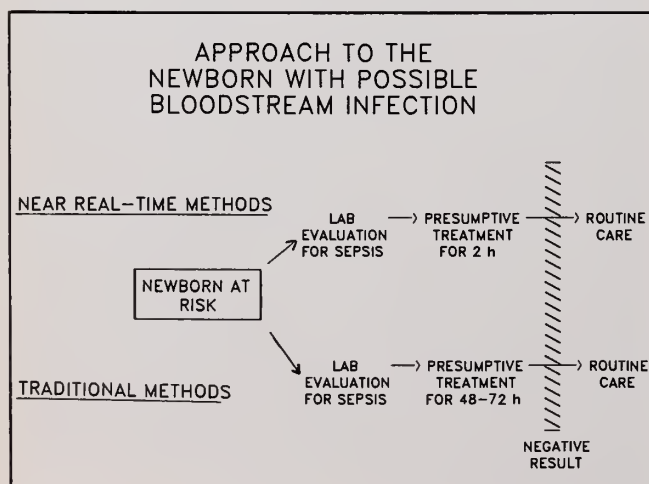
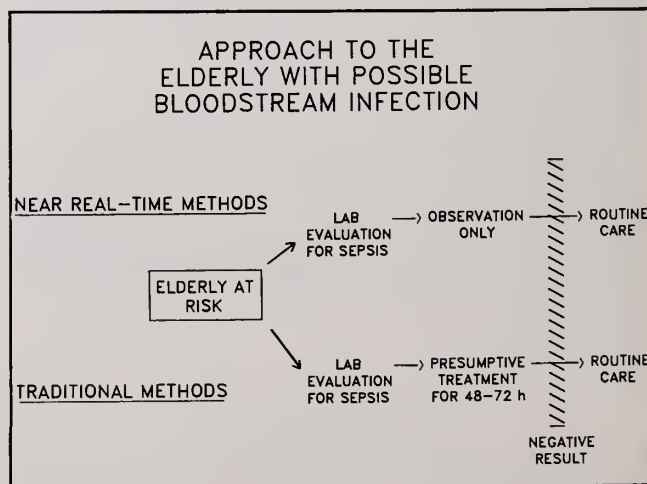


Figure 5.



like babies, have a difficult time containing infection at the source. The altered mental status may represent a simple toxic effect of fever, or it could be a secondary meningitis. The urinary tract is often a primary source of infection in these patients that can be treated effectively with oral medication if bacteremia is not present. In addition, the fever may be of no consequence, as older people also get many of the same harmless viral infections that sweep through a community.

The usual clinical approach in this situation is to move the patient to a hospital emergency room and do blood cultures, a urinalysis, a leukocyte count and perhaps a chest x-ray. Whether to do a lumbar puncture in this situation is a very difficult decision, and is usually based on the clinician's impression of the likelihood of meningitis. At this point, the patient is usually placed in the "three day rule-out" category by necessity, with frequent administration of IV antibiotics until culture results are known.

This presumptive treatment of the elderly patient also has its costs. The cost of the ambulance, three days in the hospital and IV antibiotics is in the range of \$1700 per admission. In addition, the elderly patient who is relatively functional in familiar surroundings often becomes confused and combative in the hospital. This sometimes begins a process of attempted sedation, restraints and sleepless nights for everyone involved. It is difficult not to be touched by the sense of panic in the eyes of these patients, tied to the bed to prevent self-inflicted injuries. Even the usually continent patient wets the bed in this situation, sometimes having a urinary catheter placed to prevent skin breakdown. Even without a catheter, but especially with it, the older patient is now at risk to become infected with a highly-resistant hospital organism with enhanced virulence.

The cost, emotional and financial, to the patient's family is significant also. In many areas where nursing home beds are scarce, it is necessary to continue to pay the daily rate to reserve the bed. Many families feel that they must keep a member on duty at the bedside at all times during a hospitalization, leading to exhaustion, days of missed work, and considerable friction among relatives who perceive an imbalance in responsibility for the patient.

Figure 5 shows a possible alternative strategy that could be employed if reliable near real-time methods for assessing bloodstream infections were available. The patient could be managed initially at home or in his or her nursing home environment, having blood and urine samples obtained by a nurse in the usual

way. Because the risk of waiting 1-2 hours is acceptably low in this situation, no presumptive treatment would be required. Once a negative result was obtained, the patient could remain in his or her familiar surroundings with appropriate low intensity treatment. For the small percentage truly having bacteremia, immediate transfer to a hospital for definitive treatment would be appropriate. The cost savings of this strategy is more difficult to calculate, but would exceed the amount for the newborn strategy, and will increase as the proportion of the elderly population continues to rise.

The Future

While the step from an idea with merit to a functional near real-time monitor for bloodstream infection is indeed a large one, the process is important. The link between space age technology and clinical care requires a close working relationship among members of a multidisciplinary team and an appreciation of the needs and limitations of each. Future work in this area of real-time medical monitoring could include non-invasive transcutaneous measurement of glucose and cholesterol or better tissue oxygen sensors, all current topics of interest to members of the Consortium for the Space Life Sciences.

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PRIMARY CARE PHYSICIANS desperately needed to locate in West Central Alabama rural communities. Faculty appointment with Family Practice Center at University of Alabama if qualified. Salary of \$50,000 to \$65,000 guaranteed. Generous fringe benefits include life, disability, health, retirement, and malpractice insurance, two weeks continuing education, and three weeks annual leave. All equipment, including X-ray and lab, furniture, and supplies provided. Management services including personnel, payroll, tax reports, and billing provided. If invited to visit, all expenses will be paid. All moving expenses covered. Write Health Development Corporation, P. O. Box 1486, Tuscaloosa, Alabama 35403, or telephone Al Fox, collect, at 758-7545 for more information.

PRACTICES FOR SALE — Birmingham, Mobile, Huntsville — high quality, grossing \$300,000 +, located in very desirable areas, excellent staffs, great opportunities. Call Aftco Associates (205) 985-3004 or write to 3000 Riverchase Galleria, Suite 800, Birmingham, AL 35244.

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PRACTICE ANALYST — 20 year national consulting firm with 55 offices seeking qualified candidates for senior position in Alabama. Assists physicians in practice transitions. Position requires BA degree; 5 to 7 years experience in marketing, management, sales or commercial real estate; health-care related preferred. Six figure income potential. Send resume to: Aftco Associates, 3000 Riverchase Galleria, Suite 800, Birmingham, AL 35244.

\$250K GUARANTEED FIRST YEAR FOR ORTHOPAEDIC SURGEON. Located in lovely town of 20,000 (83,000 in County) less than one hour from large metropolitan city. Office and furnishings state-of-the-art. Solo practice with coverage. Send CV to POB 6002, Tuscaloosa, AL 35405.

FPs & IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation & benefits more than competitive. Send CV to POB 6002, Tuscaloosa, AL 35405.

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EMERGENCY MEDICINE/SOUTHERN TENNESSEE: \$80-95,000 range — Choose from Medical Directorship (includes stipend and benefits), full or part-time positions in Pulaski or Winchester, TN. Hourly compensation plus professional liability insurance procedure on your behalf. Flexible hours, no overhead in moderate to low volume ED. Call Ms. Rusty Williams at 1-800-777-1301. Coastal Emergency Services, Inc., Memphis, TN.

THE MONTGOMERY VA MEDICAL CENTER is recruiting for the following positions: Internist or Family Practice Physician, Cardiologist, Nurse Practitioner. We are an active 200 bed acute care facility. The VA is an Equal Opportunity Employer. All applicants tentatively selected for VA employment in any position are subject to urinalysis to screen for illegal drug use prior to appointment. Applicants who refuse to be tested will be denied employment. Interested candidates should respond to Chief of Staff, VAMC, 215 Perry Hill Road, Montgomery, AL 36193; Phone: 205-272-4670, Ext. 4096.

SOUTHEAST USA — (ACADEMIC PEDIATRICIAN) Teach medical students and family practice residents. Direct patient care and clinical research interests required. Alabama State Medical License required. Should be board eligible or board certified. The University of Alabama is an Equal Opportunity Affirmative Action Employer. Send inquiries with C.V. to: David C. Hefelfinger, M.D., Dept. of Pediatrics, 700 University Blvd. East, Tuscaloosa, AL 35401 (205) 348-1304.

GEORGIA: Emergency Department Directorship. Immediate opportunity for experienced emergency physician in low volume, smaller community hospital. Position combined administrative and clinical responsibilities. Competitive compensation includes director's stipend and complete benefits package with professional liability insurance procured on your behalf. Contact: David Biggs, Coastal Emergency Services of Augusta, Inc., 519 Pleasant Home Road, Dept. SJA, Suite C-1, Augusta, GA 30907; (800-868-2627 or (404) 868-0186.

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Legionella Longbeachae

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Alabama Organ Center

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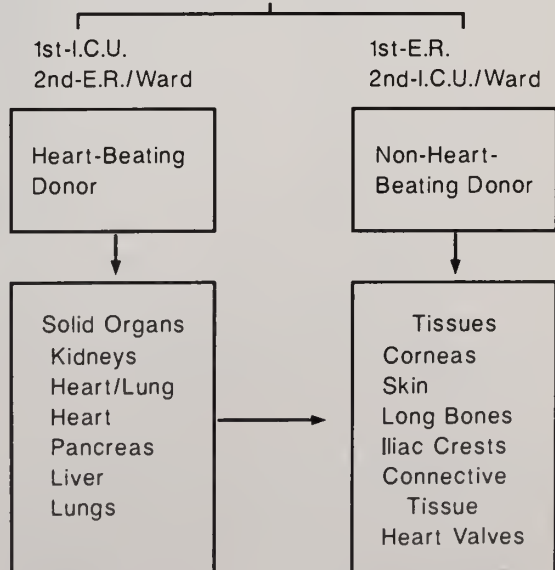
Heart-Beating Donor

Meets criteria for brain death Age: 0-65 (individual evaluation). Document history for malignancy, diabetes, and hypertension. Document infection or communicable disease. Record lab values (renal, cardiac, hepatic).

Non-Heart-Beating Donor

DOA acceptable, age: 16-65 years. Cardiac arrest following attempted resuscitation acceptable. Evaluate social and medical history. Permission for autopsy (AOC assumes costs).

Primary Hospital Location



"Continuing to Serve the Professional Community and Families in Alabama"



*Mrs. John O. Hardiman
A-MASA President*

Solid Foundation — County Auxiliaries

(Featuring Pickens, Lauderdale, and Madison Counties)

Just as the County Medical Societies are the basis of good things happening in the American Medical Association, so are the County Medical Auxiliaries the heart-beat of the Auxiliary to the American Medical Association. Projects started by one County Auxiliary are sent in to the AMAA Project Bank and soon they spread all over the country, to help in some phase of improving the health and well-being of all citizens. Last year's A-MASA President Mrs. Robert Rhyne (Marlynn) reported on the activities of Calhoun, Houston, Jefferson, Mobile, and Walker County Medical Auxiliaries. I will inform you of the varied activities of some of our other county auxiliaries this year.

The first of three counties that I am going to present to you is Pickens County Medical Auxiliary. This is a small county auxiliary of ten members that supports the state-wide projects that most Auxiliaries do, including AMA-ERF and Doctors' Day, and also carries out local projects. Last year programs were presented to the members on "Hazardous Wastes in the Home," "The Home Energy Check — A Search for Savings," and a slide program on "Rural Health in China." McGruff, the Crime Dog, visited the Auxiliary and

performed for the members as he does for the students in the county schools. Christmas cards were sold for AMA-ERF, poinsettias were placed at the nursing stations in the hospital for Christmas, and gifts were taken to needy patients in the area's two nursing homes. A video on organ donations was shown by Auxiliary members to the tenth grade students in the county schools. A dinner was held on Doctors' Day, March 30, at which time a Silent Auction for AMA-ERF was featured. In addition, a fashion show was staged, and the year was ended with a luncheon with State President Marlynn Rhyne installing the new officers. What a year, with never a dull moment!

Because of their small size, each member has a definite job each year. This is excellent training, and Pickens County has produced a State Auxiliary President, Mrs. Robert K. Wilson (Louise), and this year Board Members Mrs. William Curry (Julie), Northwest District Vice-President; Mrs. Robert Wilson (Louise), Health Projects Chairman on Elderly Health; and Mrs. Eugene Lammers (Cecilia), President of Pickens County Medical Auxiliary. Other elected county officers this year are Mrs. Jim Gentry (Debbie),

President-Elect; Mrs. Robert Sheppard (Brenda), Secretary; and Mrs. Jimmy Gentry (Peggy), Treasurer.

Next is Lauderdale County Medical Auxiliary, one of our medium-sized auxiliaries with 65 members. Last year several of their programs were planned to utilize the services of members who are professionals. One program was given by a professional violinist, Mrs. Charles Reiter (Lois); another by a professional counselor, Mrs. Foster Eich (Ginger); and a program on "Prevention of Substance Abuse in Children" by Mrs. Robert Rausch (Dr. Judith), who has a doctorate in nursing.

Local health projects included a donation to the Parent-Infant Preschool Program, a division of the Alabama Institute for the Deaf and Blind, to buy battery testers for the children to have at home, and to buy "Honey," a bear puppet to use in teaching the youngsters to sign; Christmas donations to Safeplace, a home for battered families, and additional donations to four community Christmas charities; and almost \$1800.00 to AMA-ERF from a Christmas Sharing Card that was supported by the Lauderdale County Medical Society members, as well as Auxilians.

The Doctors' Day project was providing a video tape entitled "The Chews Blues" for all Junior High

Schools in Florence and Lauderdale County. This video explains the harmful effects of smokeless tobacco to teenagers and hopefully discourages them from using these products.

The Northwest Regional Health Department received a donation of \$700.00 to purchase equipment to help reduce infant mortality and try to improve pregnancy outcome in Lauderdale, Colbert, and Franklin Counties. Other projects helping the community health-wise included a fashion benefit for the American Cancer Society, with a total of \$2,600.00 donated in honor of Mrs. Donald Thompson (Louise), one of the Auxiliary members who has cancer.

A Sunshine and Shadows Committee is active in Lauderdale's Auxiliary, and remembers medical families at happy times, such as the birth of a baby, and also helps medical families during a time of crisis. Meals are provided for families when mother and baby come home from the hospital, and meals are also provided for families suffering from grief. A support system is a definite plus of Auxiliary membership.

Traditionally each February, Lauderdale, Colbert, and Franklin Counties have a joint meeting, and the A-MASA President is a guest to speak to all three

continued on next page

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Cut Out This Number And You Could Be Removing A Future Need For Gallstone Surgery.

Use this number to call Alabama Lithotripsy Services, and offer your patients an alternative to gallbladder surgery.

Alabama Lithotripsy Services, a group of leading Alabama hospitals, has been chosen by Medstone International, Inc., to participate in the evaluation of a lithotripter to treat gallstones with shock waves. The hospitals include The Baptist Medical Centers of Birmingham (Montclair and Princeton), DCH Regional Medical Center in Tuscaloosa and Huntsville Hospital. The procedure has been successfully used since 1980 in the

treatment of kidney stones. Biliary lithotripsy uses ultrasound to pinpoint the location of the gallstones. Spark-gap generated shock waves shatter the gallstones, reducing them to small particles that can pass from the gallbladder or can be dissolved by prescribed medication.

Lithotripsy offers patients a much shorter hospital stay, a faster recovery period than surgery, and involves less surgical risk.

For additional information or to find out about a particular patient's eligibility, clip out and call the number above.

Gallstone Lithotripsy with the Medstone Lithotripter has been approved by the Food and Drug Administration for investigational use.

county auxiliaries. This is another very active Auxiliary, and two A-MASA Presidents have come from Lauderdale County — Mrs. Donald O'Brien (Evelyn), and Mrs. John O. Hardiman (Martha Anne). Other Board members this year are Mrs. Frank Hatchett (Jeannie), Corresponding Secretary; Mrs. John D. Nofzinger (Phyllis), Finance Officer; and Mrs. Ed Crockett (Dale), President of Lauderdale County Medical Auxiliary. Other officers are President-Elect Mrs. John O'Toole (Emily); Mrs. Gilbert Melson (Sharon), Secretary; and Mrs. Douglas Woodford (Donna), Treasurer.

Spotlighted last is one of our five large auxiliaries — Madison County Medical Auxiliary. This Auxiliary has 196 members, and is busy, busy, busy! Community projects in the past have included purchasing Resusci-Annies and teaching resuscitation to students in the schools in Huntsville. Continuing an Organ Donation Program in the high schools aimed at tenth grade students, over 1000 students were reached during last school year. This has been approved by the Board of Education to be taught by Auxilians in conjunction with Driver's Education, and although students are not asked to be organ donors, they are reminded that they, too, might become an "Accident Statistic," and are asked to take the donor information home and discuss it with their families. Some sobering thoughts arise from this, and hopefully serve a two-fold purpose: to increase safe driving habits, and to increase the number of donors from students' families.

Madison County Auxiliary has alternated coffees and luncheons, in order to try to reach working members who have different schedules, as well as busy at-home members. At these meetings programs have included DARE, a Police Department Adolescent Drug Program, a slide presentation from the North Alabama Rehabilitation Hospital, the Madison County Commission Chairman speaking on "What's Happening in Madison County," a program on Exercise Physiology, and a talk by the Director of the Space and Rocket Center. Social events have included a coffee for newcomers and a luncheon for Auxiliary newcomers. A Christmas Coffee is held for members and their invited guests, to include other members of the community, and a brunch is held in May for members of the out-

going Board. A Christmas Sharing Card raised \$4,430.00 for AMA-ERF and cookbook sales added another \$1,000.00. Memorials were made to AMA-ERF in honor of deceased members of the Auxiliary, Medical Society, or immediate family members. A special donation to AMA-ERF of \$250.00 was made to honor Madison County physicians for Doctors' Day. Also on Doctors' Day, auxiliary members and physicians, along with lawyers, CPAs, and dentists, participated in a basketball game which raised approximately \$5,000.00 for the American Cancer Society.

Madison County Auxilians provide food and support at times of illness or death in the family of a member, and gifts to newborns of members. They sold gift wrap and had a successful fashion show in April to have money to support their community medical help programs. Last year they gave three scholarships — one to a medical student, and two to nursing students. They had volunteers help at "Wellness Expo," a health fair at a local mall, sent eyeglasses to the "Glasses for Sight" program, contributed old metal implants to the Metal Implant program, and helped a medical mission in Belize with medical supplies. They keep wives of all Madison County physicians advised of projects, programs, and news of members through a monthly newsletter.

Three A-MASA presidents have been from Huntsville: Mrs. James Jordan, Mrs. Edwin Caldwell, and Mrs. William F. Jordan, all deceased. Present Board members from Huntsville are Mrs. Thomas M. Griggs (Dale), Northeast District Vice-President, and Mrs. Walt Grundy (Marilyn), who is Legislation Chairman in addition to Board membership by virtue of being the current President of Madison County Medical Auxiliary. Other Madison County officers are Mrs. Benjamin King (Carla), President-Elect; Mrs. Robert Ak-enhead (Linda), Vice-President; Mrs. Carl Gesler (Sarah), Secretary; and Mrs. George Harriman (Debbie), Treasurer.

Cheers for our County Auxiliaries! They all support state and national health programs, but all branch out into specific programs to support the Medical Societies of specific counties. We stand ready to help the Medical Societies in any way that we can. Call on us, and we'll continue to prove it! □

Martha Anne

Saturday, April 7, 1990

7:00 a.m. - 7:30 a.m.	Continental breakfast for attendees at orientation and educational session
7:00 a.m. - 8:15 a.m.	Full breakfast for county medical society presidents, speakers and Board members
7:00 a.m. - 8:00 a.m.	Caucus meetings for districts as arranged
7:25 a.m. - 8:30 a.m.	New Member Orientation Program (Part I) Welcome by Burt Taylor, MD, MASA President Introductory Remarks, T. Riley Lumpkin, M.D., presiding
7:30 a.m. - 7:40 a.m.	Brief History of MASA, Slide Presentation
7:40 a.m. - 7:50 a.m.	Introduction of MASA Staff and Functions, Lon Conner
7:50 a.m. - 7:55 a.m.	Young Physicians Section, Regina Benjamin, M.D.
7:55 a.m. - 8:05 a.m.	The Alabama Department of Public Health, Earl Fox, M.D.
8:05 a.m. - 8:15 a.m.	The Board of Medical Examiners, James West, M.D.
8:15 a.m. - 8:25 a.m.	Overview of Organized Medicine in Alabama, Earle Riley, M.D.
8:25 a.m. - 8:30 a.m.	Alabama Medical PAC, Jack Hyman, M.D.
8:30 a.m. - 12:20 p.m.	New Member Orientation Program (Part II) and Educational Session II — Burt Taylor, M.D. Presiding
8:30 a.m. - 9:05 a.m.	Report from our Alabama AMA Delegates, Drs. Michaelson, Sanford, Wright and Grote
9:05 a.m. 9:40 a.m.	Barbara Rockett, M.D., AMA Delegate, Massachusetts
9:40 a.m. - 10: 15 a.m.	Jim Bob Brame, M.D., Member of PPRC - Update on Activities
10:15 a.m. - 10:45 a.m.	Break to view Exhibits
10:45 a.m. - 11:20 a.m.	John O'Brien-Bell, M.D., Past President, Canadian Medical Assn.
11:20 a.m. - 12:20 p.m.	Jerome Cochran Lecture Alan R. Nelson, M.D., AMA President
12:30 p.m.	Board lunch to review Reference Committee Report
12:30 p.m.	Luncheon of speakers with MASA AMA Delegates as hosts
12:30 p.m.	Young Physicians Section Luncheon
2:00 p.m. - 4:30 p.m.	Annual Business Meeting
7:00 p.m.	Casual pool-side party at the hotel

Sunday, April 8, 1990

7:30 a.m. - 8:30 a.m.	Fellowship Breakfast Buffet arranged by Robert Eubanks, M.D. of Fairhope
8:30-12 Noon	Free time for meetings of state specialty societies and other groups
9:00	ALAPAC Board Meeting, Richard Whittaker



1990 ANNUAL SESSION

Perdido Beach Hilton Hotel, Orange Beach

Friday, April 6, 1990

9:00 a.m. - 10:30 a.m.	Reference Committee Hearings
10:30 a.m. - 12 Noon	AMA Investment Advisers Presentation on Financial Planning, Carl Gargula
10:30 a.m. - 1:00 p.m.	Meeting and luncheon of President and State Specialty Society Representatives
1:00 p.m. - 1:30 p.m.	MASA News Conference
1:30 p.m. - 4:30 p.m.	Educational Session I
1:30 p.m. - 1:40 p.m.	Opening Ceremony - Burt Taylor, M.D. Presiding (After opening ceremony, James Green, M.D., will preside)
1:40 p.m. - 2:15 p.m.	"Medicaid: Past, Present and Future" Carol A. Hermann, Commissioner
2:15 p.m. - 2:50 p.m.	"Blue Cross Update" Gene Thrasher, Patrick Ryce, M.D.
2:50 p.m. - 3:20 p.m.	Break to view exhibits
3:20 p.m. - 3:55 p.m.	"State level PRO — Current and Future Problems" Richard McLaughlin, M.D.
3:55 p.m. - 4:30 p.m.	"Physicians Liability Issues, Current and Future" A. Derrill Crowe, M.D.
5:30 p.m. - 7:00 p.m.	Young Physicians Section Meeting
6:00 p.m. - 7:00 p.m.	UAB Alumni Social Hour
7:00 p.m. - 8:00 p.m.	MASA Awards Ceremony
8:00 p.m. and on	Dinner and entertainment

(Continued inside back cover)

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February 1990

Vol. 59, No. 8

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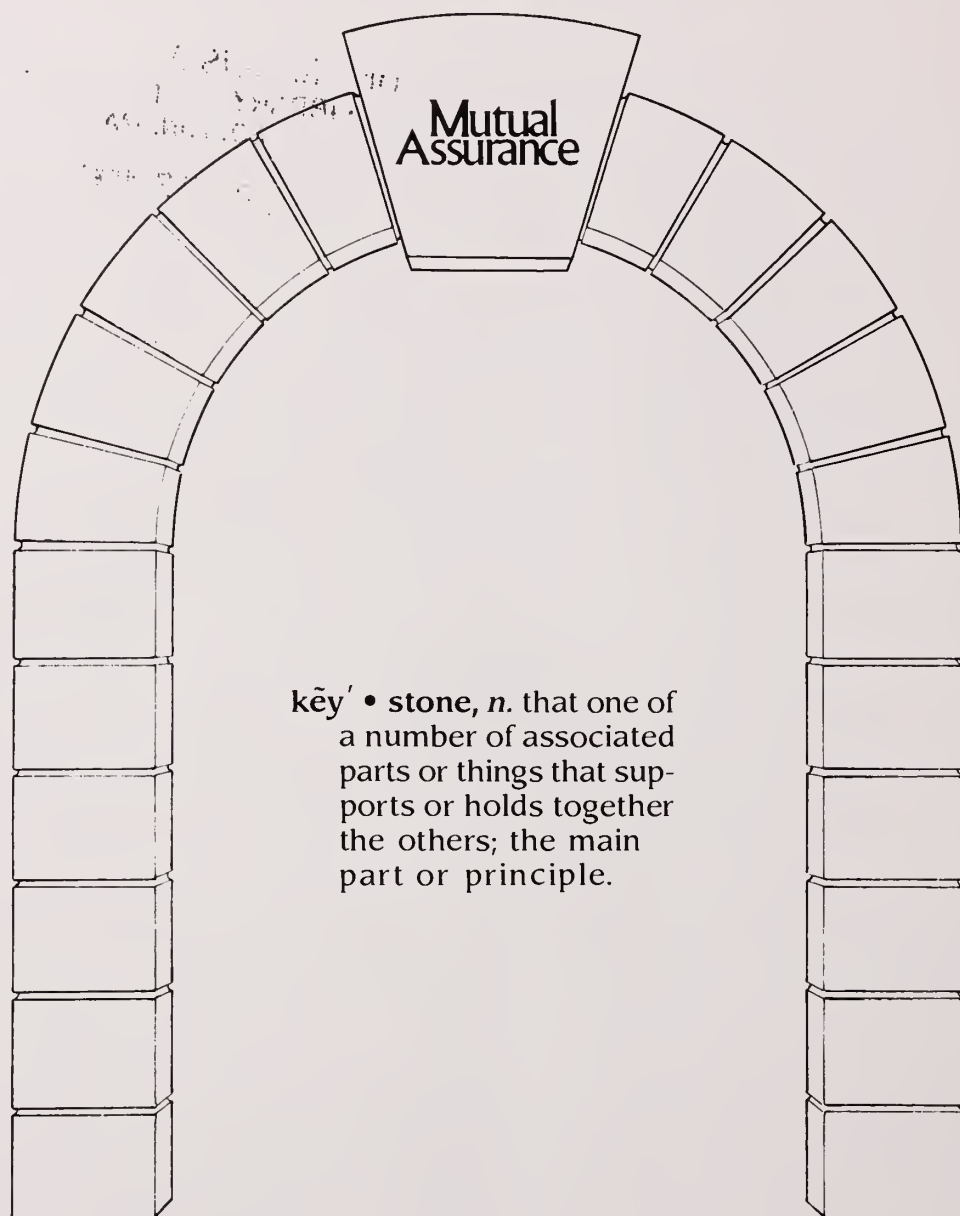
THE ALABAMA MEDICAL ASSOCIATION
JOURNAL OF MEDICINE
February 1990

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Baiting The Hook — pg. 3

The Keystone of Your Protection



key' • **stone**, *n.* that one of a number of associated parts or things that supports or holds together the others; the main part or principle.

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Impaired Physicians — We Can Help!

THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

\$10,000 - \$20,000 - \$30,000

The 1989 National Defense Authorization Act requires that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army.

The Bonus Test Program is scheduled to begin on or about August 1, 1989 and will be offered to physicians in the following specialties:

**ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY**
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

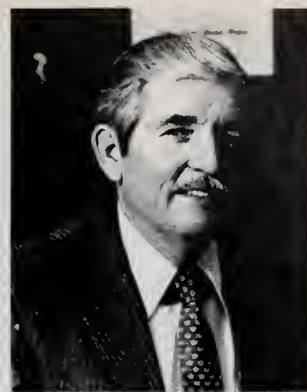
BONUS AMOUNTS: The test will offer \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM
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S. Lon Conner
Executive Director, MASA

Baiting The Hook

In his President's Page this month, Dr. Taylor lays out for your inspection the impressive list of provocative speakers awaiting you at annual session April 6-8.

That is the heart and the *raison d'être* of annual session, but along with such stimulating and heavy fare, the soul of *homo sapiens* craves the hedonic dimension as well.

And at "America's Riviera," as the promoters have dubbed Alabama's gulf shores, you will find that aplenty — good company, excellent food and what one travel folder describes somewhat lyrically as "a combination of emerald waters, the Gulf of Mexico's sugar white sand beaches."

Add to the natural scenery all the amenities of the Perdido Beach Hilton itself — four on-premises tennis courts, a heated indoor-outdoor pool, the Perdido Beach Health clubs with a good beachside view, three nearby golf courses and more — all thoughtfully designed to make burning calories almost as pleasant as taking them on, with the hotel's superior cuisine: the Cafe Palm Beach; fine dining in an elegant setting at the Voyagers; dinner dancing to live entertainment at the Nightreef; and, for the more introspective, a soothing piano in the Sandpiper Lobby Lounge.

Many Alabama physicians have first or second homes in the area and there will likely be invitations beyond

the smorgasbord provided by MASA to make the 1990 annual session a memorable beginning for our last decade of this old century.

The hotel itself is beautifully appointed and affords plenty of pleasant diversion to spouses while physicians are in meetings.

Since the April 6-8 annual session is a couple of weeks earlier than usual, and April is Alabama's most splendid month, this trip will iron out the kinks of winter and whet your appetite for the summer ahead.

Who knows, one taste of the Alabama gulf coast in such a congenial atmosphere of old friends and new sights may persuade you that the area may well be an idyllic spot for *your* home away from home. It happens; ask the many physicians who have already made that discovery.

First of all, we want you there for the superlative programs we have worked for months to provide, which Dr. Taylor presents in his column. But if an extra measure of convincing is indicated, the sybaritic pleasures of Perdido Hilton and Orange Beach for the whole family ought to just about do it.

See you there, April 6-8, and remember those beguiling words of the travel literature "... emerald waters, sugar white beaches ..." in just about every body's favorite month.

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Frank Cochran

Perhaps you are considering purchasing an existing practice and need:

- Someone with experience to consult with in the process, or
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*Burt Taylor, M.D.
President, MASA*

The Rest of the Story

Thanks to the national media, we have all heard about the wonderful Canadian health care system. United States citizens and Canadians agree that Canada's health care is the "best" in the world.

During the recent AMA interim meeting I was privileged to attend a forum which dealt with national health insurance. Each speaker represented a country that currently has a national health care system. Dr. John O'Brien-Bell, immediate past president of the Canadian Medical Association, spoke to us about the real picture in Canada.

Immediately after the forum I asked him to come to Gulf Shores in April 1990 and address the Alabama physicians at our annual meeting. Several weeks later, after reviewing his busy schedule, he has agreed to come and speak to us. I think you will find Dr. O'Brien-Bell is an interesting speaker. He has an important message for all of us. Perhaps the media has failed to paint a totally accurate picture.

I am delighted to inform you that the current President of the American Medical Association, Dr. Allen Nelson, an internist from Utah, has agreed to be our Jerome Cochran lecturer. This physician represents us extremely well. I hope most of you can meet him. He works hard every day for the physicians of America. He is a very warm and friendly person. I think that you will enjoy this opportunity to meet this outstanding individual.

The State Medical Association has decided to alternate the annual meeting between the Perdido Hilton Hotel at Gulf Shores and the Winfrey Hotel in Birmingham during the next few years. The meeting facilities are excellent and the room accommodations are far above average. This year we will meet at Gulf

Shores April 6 through April 8. Details of the meeting will be forwarded to you during the next few weeks.

Through the years the presiding state president has been given the opportunity to structure the annual meeting. I have enjoyed working with the Medical Association staff in developing this year's meeting. We have made a few changes. They are not permanent. They are based on my perception as to why we have an attendance problem. I feel the proposed changes will interest physicians working in any specialty area and every region of the state, including the rural areas and our cities.

We have been working on the program since early August. The major goal has been to arrange a program that will interest all physicians during each segment of the busy Friday and Saturday sessions. It is very difficult, if not impossible, to structure a CME program that would satisfy each Alabama physician, since we each have such diversified medical backgrounds and training.

I have decided to eliminate the usual CME program and try to arrange a socio-political program that will be pertinent and as up-to-date as possible. Each of us has opportunities throughout the year to attend CME courses concentrating upon our own field of specialization and specific interest.

Therefore, I have tried to arrange a program that will address our major practice problems — insurance including reimbursement and liability, potential national health insurance plans, AMA activities, Medicaid, Medicare, PRO, political activities, and many others.

We have attempted to streamline the meeting and have tried to keep most of the activities available for

all participants rather than separating the physicians into smaller groups meeting in different places at the same time.

I believe the speakers will interest the new Alabama physicians, who are required to attend their first orientation session, as well as those physicians who have attended for many years. I am pleased with the final draft of our program. All of the MASA staff offered suggestions. I made the final decisions and if you do not like this present format let us know and I am sure Dr. Riley Lumpkin, your next president, will consider your suggestions as he plans for April 1991.

The PPRC (Physician Payment Review Commission) has significant influence with various congressional subcommittees. Policy decisions concerning physician payment are influenced by the PPRC recommendations. There are only two actively practicing physicians on this 15 member committee. We have invited Dr. Jim Brame to speak to us and give us some information regarding the present and possible future activities of this important committee. Dr. Brame, from Texas, will address our Saturday morning session.

Last year I attended a Reference Committee at the Annual AMA Meeting. I listened to a physician from Massachusetts speak generally in opposition to the "Massachusetts Miracle" and explain how that state's physicians have really suffered due to state (not federal) legislation and the activities of their governor, Mr. Dukakis. I have invited Dr. Barbara Rocket to speak with us and I believe you will find her comments extremely interesting. Certainly, it should spur most of us to remain more active in our state political activities.

The problems with Medicaid continue. Eligibility for Alabama Medicaid is the lowest in the nation. A family of three cannot have an annual income of greater than \$1,416 to be eligible. We have difficulty understanding the problems with Medicaid. We all realize that the payments for our services simply do not cover our costs. The Alabama Medicaid Commissioner, Ms. Carol Herrmann, has agreed to try to help enlighten us about the current problems and what we might expect in the future.

For the past few years there has been a persistent problem with our understanding the changes and the complexities of physician reimbursement, particularly with Medicare. As you all realize, Medicare is administered in Alabama by Blue Cross-Blue Shield. Mr. Gene Thrasher of Blue Cross and Dr. Patrick Ryce, Medical Director, have agreed to speak to our annual session on Friday afternoon. They will be available for questions, as will all of our other speakers.

Dr. Derrill Crowe will discuss the current liability insurance situation and projections for the future. Dr. Crowe has guided Mutual Assurance through some tumultuous times and, as you know, Mutual Assurance has received A.M. Best's highest rating.

Your five-member AMA delegation will speak to us and discuss problems and activities of the American Medical Association. They will try to answer any questions which you might have regarding the AMA. These physicians work very hard and represent Alabama positively and effectively.

Political activities will be in full swing by April as the Democratic and Republican primaries will take place in June 1990. We will have a brief presentation by Dr. Jack Hyman, the chairman of ALA-Pac.

Dr. Earl Riley, a general surgeon from Birmingham, who chairs our Board of Censors, will give us a brief over-view of organized medicine in Alabama. Dr. Riley does a tremendous job and uses his experience to keep this very important group of physicians working smoothly.

The Board of Medical Examiners is becoming more active each year. Their actions can effect each physician in Alabama. The legislative "watchdogs" of medical activities are constantly scrutinizing this Board. Dr. James West, a surgeon from Anniston, Alabama, is the chairman and a superb leader. He will bring us up-to-date on the activities of your Board of Medical Examiners.

Dr. Richard McLaughlin and his staff will discuss the State level PRO. Dr. Earl Fox will discuss public health and be available for questions. There should be tremendous interest in these presentations.

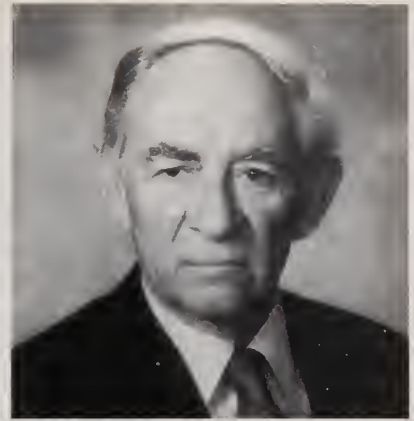
The business meeting will be held Saturday afternoon rather than Sunday morning. This should give the physicians from the northern parts of the State plenty of time to travel on Sunday. A prayer breakfast will be held Sunday morning. Meetings rooms will be available for any group planning to get together Sunday morning.

We will have a luncheon for the State Specialty Society representatives on Friday. On Saturday there will be a breakfast for the County Medical Society presidents. There are many other activities that have been arranged. Hopefully we will have some cooperation from the weatherman and we all can enjoy a beautiful weekend along the Gulf of Mexico.

There you have it. Please make arrangements to attend. The strength of our Association is based upon you, the members. We need to stay together and try to develop a very strong State Medical Association.

I look forward to seeing you in April.





Claude L. Brown, M.D.

“The Good Old Days”

*... And live and die,
Make love and pay our taxes,
And as the veering wind shifts,
Shift our sails;*

— Byron (Don Juan)

A solid description of this title necessarily escapes definition; we are dealing with a nebulous item, a gossamer outline that evaporates in the light. But the phrase must have meaning since it is such a common one. However, I don't recall ever hearing anyone under 30 use these words.

Does that observation, if true, imply that one needs a certain period of time to grow into a wider view of one's life, in order to point at certain intervals and term them “good”? We do usually refer to past times; often we conjure before our vision a simpler existence, one of less ambiguity and with a narrower range of self-expression. The “good days” typically involve a different kind of responsibility: the responsibility may be large, but it tends to be less complex, related to fewer people or institutions.

Principally, we recall the emotion that we felt, and call it “good.” We remember that during this time we were more content; that our skirmishes with the world less troublesome; and we greeted each day with gratitude. We were happier in the “good old days.”

Occasionally, instead of recalling good times, we project our expectation for such halcyon days into the future. When the mortgage is paid, when I retire, when

the kids are grown, then this lithopedition that I carry next to my heart will lighten, the fields will blossom, and I will breathe the balmy airs of Zion. It is only human to have these wishes; surely it is maturity to know that such golden fantasies can rarely be other than partially fulfilled.

In my waiting room hangs a picture by Sir Luke Fildes entitled, “The Doctor.” Fildes excelled in portraying the poor of London and in this picture he plainly is in a poor house.

The picture is dark; its background somber, brown, black. Light comes from a lamp on a table in the left foreground; it shines over the shoulder of a doctor, seated in a chair, and illuminates the patient. This is a child about six, lying supine on a makeshift bed made of two chairs brought together, with dingy coverlets over them and half covering the patient. The child's eyes are closed, the right hand over the chest, left arm fully extended. Bending forward on the edge of the chair sits the doctor, his gaze intent on the patient, his head supported by the left hand with elbow resting on his knee. On the table are a cup and a medicine bottle; behind the patient in the shadows is a man observing. One palpitates with the tension in the doctor. He is truly up against it; the medicine has been given, whatever available comfort has been dispensed, his armamentarium is empty, his pharmacopeia is exhausted — he can only watch, wait, perhaps pray.

A copy of this picture hung on the wall in the waiting room of Dr. Snowden, the family practitioner whose office was next to my father's drug store. The pre-

dominant sentiment that it produced in me in the years that I frequently saw it was pathos. Unquestionably, the painting holds magic for me. Standing alone in my office now with the late afternoon sunlight streaming in the window I can close my eyes and behold!

I am transposed to a summer afternoon of 50 years ago. I see the poor country folk in Dr. Snowden's small, bare waiting room shuffle their feet, blow their noses, mutter to each other. A child cries from the doctor's examining room; the telephone on the doctor's rolltop desk rings. Through the screen door come street sounds; the clop-clop of a horse's hoofs, gravel grating under the wheels of a car, distant voices, and from two doors away the music of Luigi Luprelli, the shoemaker, who, above the noise of his machine, is playing his phonograph loudly and singing: "La Tempesta Del Mio Coar." Instead of an impoverished cobbler, Luigi is a Count of Aragon, and I too dream of myself as a magnificent figure, a doctor.

Are these the "good old days"? No one can yearn for return to such limited processes. At the same time (and in the same locale that Fildes painted his picture), Lister was crusading for antiseptics. Sterile technique, sanitation, antibiotics — these battles have now been won. Unimagined blessings of technical progress occur in the surgical specialties, in diagnostic areas, in drug therapy, and understanding of genetics. We no longer have the privy but we are (even more successfully) poisoning the rivers, the oceans, and the air. We are strange creatures.

In one salient feature of the painting, however, we undergo no change at all in our wishes. The doctor is absorbed in contemplating his patient; there is nothing between him and her. She is the center of his intense concentration. If he spoke, she would respond; if she sighed, he would hear; were she to move, his response would be ready. Other than penicillin, what more could a patient want? Every patient wants to feel this attentiveness from their doctor. It is incorrect to generalize that we replace our personal caretaking with the modern technological treatments that are now at hand, but it is true that these very techniques do come between the patient and the doctor. I refer to hospitals with their staff and devices; to technicians of all kinds; to the business aspects of medicine. But the wish of the patient (and quite likely the secret wish of the doctor) is that, despite and beyond all these necessary intrusions, there remains the steady compassionate understanding that is the core of the professional relationship.

The "good old days" were not all filled to the brim with this type of understanding. But the paucity of other therapeutic factors made the doctor-patient relationship much more personal and this is what is desired. We cannot find again the "old days" nor is there any reason to do so. But, we very much need to keep this feature of them vividly alive. □

Information for Authors Concerning Manuscripts

Manuscripts from member physicians should be typewritten, double spaced on white paper 8½ x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

Style: The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

The Stylebook/Editorial Manual, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E. B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged. Second Edition.

Length of articles: Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

Reprints: Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed to *Alabama Medicine*, The Medical Association of the State of Alabama, P. O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

In Pursuit of the Moment

Charles H. Smith, M.D.

Abstract

When one paper is a sequel to a previous one, it is altogether too simple to bore the reader with redundancies. It is also quite too easy to lose track of time and jump from one paper to the next and this almost certainly will happen in the present one.

Portions of the earlier writing are initially presented and one would hope that these present a valid reason to continue pursuit of "The Moment."

After some discussion, it is felt that various previously unmentioned facets of "The Moment" are discussed and perhaps clarified. But it is not defined. It may defy definition and we could hope that this might intensify our pursuit, since physicians *are* a stubborn group.

Not long ago (March 1989), *Alabama Medicine* was kind enough to publish an article in which the writer on several occasions referred to what he called "the moment." Faced with summary and the need to define what precisely was meant by such a reference, paralysis set in. The following definitions were presented:

"The moment could be described as that point at which the patient realizes that his therapist grasps the nature and enormity of his problem. That is true but not sufficient, not nearly so. During 'the moment' the patient realizes that the therapist really appreciates the fiber of his being, his fears and strengths and his *human worth*. . . . If 'the moment' arrives, the treating person has perceived the patient's ego, his self with a clarity immune to argument. He can humbly say '*I know this patient*.' This is the moment."

What is so wrong with these definitions? Easily a half dozen or more things. They lack a necessary cohesiveness. To state that a vague sort of definition is

"immune to argument" is to vastly underestimate the capacity of doctors to argue about any and every imaginable subject. We would not wish it otherwise. Consider the idiot who first suggested that one pause to wash his hands enroute from the autopsy room to the delivery room. Why wash? Wash what? Not a hero among his contemporaries, Simmelweiss proved to have a germ of an idea.

Although the moment was earlier discussed in terms of psychotherapy, it embraces all of medicine. A single example should suffice. As an intern, the writer scrubbed many times with an aging surgeon who could palpate a breast nodule and predict with unfailing accuracy whether it was malignant or benign. "Doctor F., how do you know?" "I don't know, I just know." Not a masterpiece of clarification, but true. He did not know, he just knew.

The young physician could not quite accept this so he began to watch the surgeon's fingers, his technique of examination, finally his eyes. Slender fingers could essentially encircle the small mass. Greenish brown eyes stared in neutral, then brightened and he would say, "It has to be removed but I think everything will be all right" — benign. A second, third, perhaps fourth palpation, a little moisture in the eyes but no change of voice, "We have you scheduled for 8:00 in the morning" — malignant.

So simple for one, so nearly impossible for another surgeon of otherwise equal competence. Dr. F. could not explain it, but he had his moments. Fingertip Mammography well ahead of its time. And illustrative of the fact that moments, all of them, can either be sad or happy, depressing or joyous.

The intern learned with perhaps 95% efficiency to replicate the surgeon, but this is a 5% deficiency rather than otherwise. Examine it any way you please, but it comes up 5% short. From a strictly selfish point of view, the intern knew whether to expect a 30-minute procedure or forget his lunch. Practically, it made not much difference as he was likely to be captured by

another surgeon before making a clean escape from the OR.

There is perhaps a peculiar mentality among people associated with medicine which strives and drives for the 100%. It may be akin to a dog chasing its tail, the tip of which is only an inch or so away. It is a reality, but a little beyond reach. So we chase and chase and perhaps never reach our destination. But the next generation may come closer and the next achieve its goal. That is a moment.

The moment does not belong to those multiple journals priding themselves in presenting such "Clinical research" as providing us with the information that antidepressant A) and placebo B) result in similar improvement in C) males over 40 and D) females over 40 and terminate in three pages of references to which no one refers. This is not research nor will it ever be more than a means of inundating a journal between advertisements. There is no object in reading beyond the abstract. Such articles are all but mindless and there seems to be some hint in recent years that more journals are recognizing this. Except those with mindless editors. The Archives of this and Clinical Journal of that can last only so long without delivering some stimulus to the prefrontal lobes.

The strictly research oriented scientist obtains grants in order to buy various mammals and equipment and prove or disprove a given theory. He is not to be

demeaned, he is essential. And he is probably more likely to achieve his mini-moment than most. He has carefully charted his course without the distraction of patients and it cannot be overemphasized that without his efforts nothing would ever even get started. Having given him his due, we can return him to the laboratory and concentrate on the clinician who is concerned with moments, not minutiae.

In writing of special moments, the physician is naturally inclined to write of those happenings which relate to his own recent experience, in this instance, psychiatry. The reader is only again invited to recall that special experiences happen in every area of medicine.

The Building of the Moment

The writer may have given the impression that the moment occurs only as some kind of supernatural experience. Possibly some Divine intervention. Not so. Dr. F's remarkable sensory touch could be seen as a Gift. If so, it became his responsibility to capitalize upon it.

This special thing is built brick by brick. It is not ordained. Ideally it begins before the therapist and patient ever meet; in the outer office. Many physicians are remarkably ignorant of the conduct of their receptionists, insurance clerks, etc. The patient is not; he is remarkably sensitive. When the receptionist acts as though intent upon protecting the doctor from annoyance by the patient, he/she may perceive that this is his or her duty towards the physician. The patient has no such notion. He may enter the consultation or examining room with elevation of blood pressure and pulse, prepared to dislike the physician. The patient does not regard his physical or mental health as any sort of game. The doctor is too likely to counter genuine grievances with "Uh huh, take a deep breath."

The writer has had the good fortune for a number of years to work with a young lady who is acquiring a Master's degree in Psychology. Long before working on a second degree, she was naturally endowed with an empathy which transmitted to the patient. Since she has contributed much to this article, she is free to compliment herself at length, but probably will not do so. It is very gratifying to hear a patient say, "Your receptionist is a very nice person (therefore I am giving you the benefit of thinking you must be, too)." The groundwork has been laid.

But groundwork is just that, groundwork. It is clearly necessary to have a solid foundation but a building block may easily be inserted out of place or dislodged or otherwise go awry and destroy if not delay one's objective which is cure.

Again, to minimize the possibilities of a stillborn effort, responsibility begins in the front office. Replies are hopefully empathetic but not always sympathetic. "No, your refill is not due for five days, yes, I will

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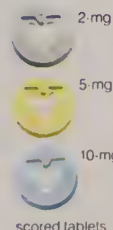
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talk to the doctor and see what he says." It is evident that after checking with the doctor there may be no option but to become hardnosed. It is something of a rare positive if one's employee is able to say of perhaps an anxiolytic "this has a short half life and it could endanger him if he is withdrawn for five days." So the physician thinks and will probably come up with a compromise. The prescribing of anxiolytics is essentially universal among physicians and one wonders how many know what they are prescribing. The first anxiolytic was without question alcohol (capable of producing psychosis), the second probably the Bromides (almost certain to produce a psychosis with prolonged use). The third must have been Meproamate (1955 or 1956). Lastly the Benzodiazapines, Chlordiazepoxide was marketed in 1961 and is still in popular use. Which moves one to ask how many physicians know what Chlordiazepoxide is and what percent of such physicians have the most remote ideas of its approximate half life. While on the subject of anxiolytics, one should probably mention that nearly everyone knows Alprazolam appears to be the most effective of currently available such medications but it is only the most safe when prescribed in minimal dosage or the patient is monitored carefully, ideally both. It has a short half life and when prescribed for a Panic Disorder, minimal dosage is rarely effective.

Routes to the Moment — Freudian

Dr. Freud may have experienced more moments than anyone before or since. He was officially pronounced dead about 50 years ago yet he is still often referred to in the present tense. One seldom speaks of his dream interpretations as "Freud said," rather more likely "according to Freud." His books were burned in Berlin in 1935 and he commended civilization for choosing to burn his books rather than their author. He was evicted by thugs from his home in 1939 and died months later in a foreign land.

He is eternal and would be so if he had never written beyond his early case histories. So what is to be learned from these cases? That the man was basically a diagnostician and as such realized that the physician's indispensable diagnostic tools are his *eyes* and *ears*. Look and listen. Read or reread some of his early studies, e.g., the young lady who thrust her fingers in and out of her reticule. One can accept or reject his interpretation while respecting the capacity for observation. Having progressed somewhat beyond the Victorian Age to what might well as not be termed the Cocaine Age we could include the fingertip as a primary diagnostic tool while keeping in mind that there are ten lawyers for each digit.

Genius cannot be defined simply in terms of observations but neither can it become everlasting without them. Consider Michaelangelo or Leonardo. It is

doubtful that even a genius can properly identify genius.

How Long is a Moment?

A moment has been defined as "a minute portion of time . . ." and most would agree. This is why we feel a strong urge to kick ourselves or something when we realize that this tiny fraction has passed us by and will be difficult to recapture, impossible to recreate. Having been alert or fortunate enough to capture the moment, there is no reason one can't ethically exploit it presently or in the future in service of the patient. An example comes to mind; a Viet Nam veteran whose case was discussed in some detail in the March issue already mentioned. Initially he chose an uncomfortable chair in preference to a more comfortable leather one. In this way he could distance himself from the therapist and even from his vision, since a desk lamp sat between us. For a while, he thought of excuses to leave early: he had to pick up his children from school (they travelled by bus), one child was sick, he had seen a suspicious looking person near his house, etc. After a surprisingly few visits, he was a little upset when a buzzer sounded signalling the end of the hour. Following a brief pause, he smiled, he laughed aloud saying, "I guess I trust you now." This trust literally extended to the outer office.

These few sentences are not without significance in this patient suffering a Post Traumatic Stress Disorder. Trust does not come easily to him. It may well have originated through empathetic interchange between the secretary and the patient's wife outside the arena of psychotherapy. Assuredly, it could not have happened without some verbal or nonverbal bond between the two since the patient trusted no one outside his family. Additionally, it debunks any idea that the moment is a thing of high drama; if it were, we would all remember it. It is not the stuff of which Perry Mason is made and would not impress 007. In the line of duty, the patient may have killed more people than double O, but only with a rifle or grenade, nothing exotic. Hum-drum everyday stuff. The stuff which made him gravely ill but did not impress his countrymen. Except sometimes in a negative way. Told to burn a village, he did precisely that, not for the joy of it but because Intelligence felt Viet Cong were there. Can Intelligence ever be wrong? Nonsense question. Is Intelligence more often right than wrong?

Meanwhile, the patient is presently struggling with an immediate problem. Should he cut expenses by giving up smoking? When he stops smoking, his appetite increases so the grocery bill goes up. Solution: stop smoking and cut to two meals a day. With apologies for wandering from the subject (whether we feel apologetic or not), we return to the study of the undramatic moment. This patient has become more self-assertive, even to the point that he recently reported

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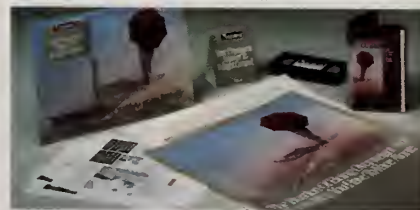
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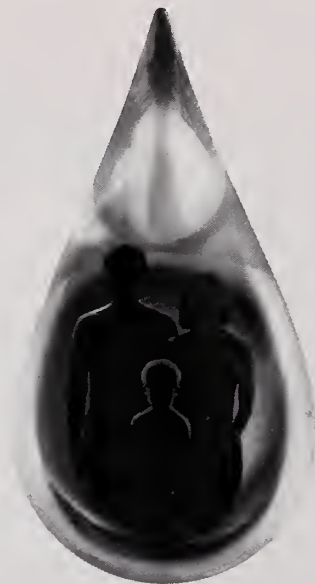


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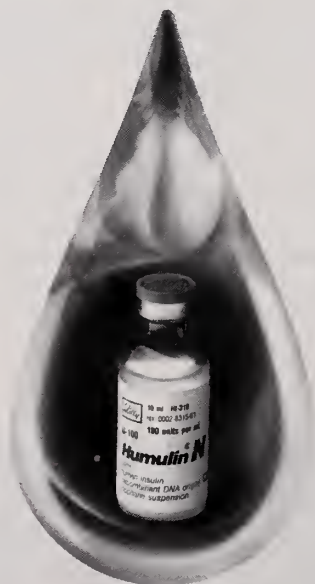
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a suspected burglary and endured the invasion of uniformed officers into his home. Not a great leap forward, but a substantial step for this patient. Or maybe it could be termed a smallish sort of miracle.

This brings us to the business of benign exploitation. So the man says he trust you, so what? This is what: He remains far away from the mainstream of life, very far away even from the ghetto life he left at age 17. He is not likely to progress further without properly timed prodding into a vocational rehabilitation program. He will respond with the old fears and suspicions and react negatively. "Do you remember when you said you trusted me?" He remembers. "This is what I think is best for you and your family." Hitting below the belt? Not if it works. Not if it is a moment which changes the patient's life for the better.

The whole business of medicine has always had less to do with methodology than with *what works*. And we wonder whether our children in medical school or residency, any residency, are being taught what works. What works as opposed to the X-ray leading to the CT scan, the CT to MRI and they all lead to multi-consultations. We are speaking of valuable tools, certainly not ones we would surrender. What we wonder is whether the student is using the sensory tools with which he was born, eyes, ears, hands. CATs and MRIs look well during a Clinical Pathological Conference but we would prefer the Pathologist not always have the final word. We would no more want to surrender helpful diagnostic tools than we would want to surrender those computers which keep us aware of what our automobiles are doing, the number of gallons remaining in the tank, the expected miles of travel anticipated from those gallons based upon the computerized miles per gallons and the ability to raise, lower, incline or recline our car seats and to view it all on the dash board. All this and much more.

What happens when our computerized car encounters mountains, rain or multiple factors not predicted. We must use our senses and common sense, something we have done before. We don't expect any of this to happen but we want to be prepared for any eventuality. And we want our young physicians trained in the same way. We want them trained to use a Model A in the event of failure of CT. This is necessitated largely because of the physician's inclination to gimmickry. How many physicians own computers which they neither need nor know how to operate. Computers should begin with a shift stick and progress along with the physician to computers which are, well, computers. For certain there will never be a computer which will capture the moment and convey it in a "minute portion of time" to the treating person. There ought to be a moment of reflection and confession. This writer can only imagine a floppy disc as something one could use to wash or wax his car while his spouse can actually operate one of the larger computers while never having

suffered through a moment in a classroom. Which simply confirms our suspicion that brain and necessity will bring a computer to a heel.

The writer was recently informed that the office typewriter would easily connect to a computer. Doubtless a favorable comment on the typewriter but to what avail? The machine seems to work fairly well in its own right, ignoring typographical errors. It might easily or equally well toil with the vacuum cleaner but unless it can awaken the operator to the task at hand, it won't serve much purpose.

However, having learned that the typewriter will work with a computer, the writer is bound to learn more. Will it reduce office time? Will it help in the treatment of patients? Could it in some mysterious way hasten, or heighten or otherwise facilitate the moment? The computer is here to stay so its possibilities demand recognition, its shortcomings deserve the same recognition.

Environmental Aids to the Moment

The outer-office importance has been discussed and needs no further recognition. The arrangement of the inner office, while largely dependent on the taste of the therapist, has some impact on the patient and must not be ignored. The patient who stares into the bookcase is delivering a message, a negative one, but not to be overlooked. Just how interested can a patient be in studying *Harrison's Textbook of Internal Medicine* in its outer cover? Clearly not very. When does one intervene? Regardless of tentative diagnosis, soon, very soon. The patient may be Schizophrenic, depressed, or both, but he is going nowhere studying the covers of a hundred volumes. This sort of behavior is commonly referred to as avoidance of "eye contact." It is well within the therapist's power to demand such contact and hold such contact at any time.

He can do so with a sense of urgency, a voice of command, or "If you're afraid to look at me, who can you look at?" You will get the patient's attention and you can rivet that attention. During the next session the patient may wear sunglasses. A gentle voice of urgency will usually do. "I can't treat a patient I can't see and I can't see you with those glasses." But things are not so simple. The patient may sometimes wear his/her sunshades to signal a reversal of emotions. He may wear the glasses as a sort of joke, knowing they annoy the therapist. One studies the lips, are they turning upward just a bit? The patient may abruptly remove the glasses and smile. Or he may not. Once the shades are removed, it is usual that tears may be seen. Tears of sorrow or of a sense of progress? It won't take long to tell.

The eyes behind the sunglasses are quite alert and perhaps should be tolerated for a period of time but not an indefinite one. The therapist has both the right and, more importantly, the responsibility to insist on

a one to one give and take relationship with his patient. There are alternatives. "Come back when you are ready to talk" or "perhaps you should see Dr. X who uses strictly psychoanalytic technique so is invisible anyway, you will have no need to hide." If both therapist and patient are prone to hide, it is difficult for the writer to imagine anything constructive taking place. The writer is inclined to think that in most cases the patient, in or out of awareness, wants the shades removed.

It would be comforting if the whole of psychotherapy could be defined in a sentence, a paragraph, even a book. If this were so, we could rapidly and with supreme confidence move toward the moment. Occasionally the moment may occur very early but this will not be because of anything anyone has written. It will happen because the patient has pretty well figured out what needs doing and needs only the opinion of an "expert." Such a thing is rare but should be treasured by the therapist because he has had the good fortune to witness a successful instance of self analysis.

Furnishing the Office

This is mentioned only because some undue attention has been accorded it lately, at least largely undue but with no intent to deprive the treating person of his toys.

The most important thing to remember is that there are two, only two, significant items of furniture in any office: The patient and the therapist, in that order. Otherwise the furniture can probably be thrown in almost any direction with an exception or two. The patient should be allowed the (transient) luxury of fear. He/she needs space to retreat. He or she may require also the opportunity for closeness, especially the child or adolescent who lacks the verbal facility to fully express his feelings in words. A plain old fashioned desk with a couple of chairs would seem to meet the needs of the patient. He can adjust his distance to meet his needs of the moment. And he can do so in what he erroneously believes to be in an inconspicuous manner.

For reasons long forgotten, if ever understood, the writer has a couch in the back of the office. It is not unusual for a patient after a number of visits to remark, "You know, I have never noticed that couch before." The patient has certainly seen the couch but the words should not necessarily be taken at face value, though we do see things every day which simply do not register. Definitely it may be tempting to feed the ego and offer a sexualized interpretation and the writer feels that this would be more often than not a mistaken interpretation. But the patient is usually saying something and the author has his own interpretation. What the patient is saying is that, "I have shared many crucial moments with you, I have told you that my father sexually abused me as a child, my husband is

a dependent alcoholic, my job is stress filled, I am anxious and depressed but you have told me nothing of yourself. Don't you have miseries to share, what and who are you, it's your turn."

This is not a transference. It is the patient saying, "Fair is fair." The patient is not saying, "We will change roles and I will for a time be your therapist." We can accuse the patient of this and we will lose a patient, undo whatever may have been accomplished and make things doubly difficult for the next therapist.

Having worked oneself into what could modestly be called a dilemma, the best solution might be something very close to the truth. "I may have been a little more fortunate than you but I have certainly had childhood and adult traumas and I don't mind sharing them where they are similar and my solutions may have turned out luckier than yours but we can't both be patients at the same time. We don't expect you to be a patient forever and when you aren't a patient any longer we can sit and discuss our life histories. And we will probably bore each other to tears."

This, I think, is about as frank as one can be with a patient and still maintain an appropriate doctor/patient relationship. The patient has rights and with those rights go responsibilities. Not the least of those rights/responsibilities is the need to interrupt the therapist's monologue when the patient feels a moment of urgency, a responsibility to call a halt to what is being said and share the moment, emphasize it, insist on its exploration. That therapist who is somewhat in his right mind will stop, look and listen, digest and respond. There will be a few, fledglings or experienced egomaniacs, who will swell with resentment.

The former can be forgiven, the latter is already in the process of self-destruction. If one may be allowed an effort to simplify that which defies simplification, both patient and therapist have certain obligations and this is true and this is important. Beyond this it is necessary to say that, by definition, psychotherapy involves at least a patient and a therapist and the therapist is the leader. If it is otherwise, if the therapist's humility is such as to allow the patient to assume control, then the whole process has come apart, it has no worth. Again, if the therapist is too full of self importance to respect the patient's thoughts and feelings, the bottom has already fallen out, in fact, never existed.

Academic Responsibility

The above situations do not occur often but they do happen and they happen more often than we would care to admit. We look again to the teachers. Would one dare to terminate a residency of the young physician who knows that he will be at the very bottom of the physician's pay scale? The academician does not. But spotting a loser, he should. He very well should and if he does not, he should evaluate his own

medical worth. What is the worth of an academic coward? Small. Negative. Somewhat under zero. The resident is abused and medicine is the loser if a resident not suited to his field is allowed to continue to study in a field in which he is inept. Such a statement seems so obvious as to sound absurd. Yet one knows from experience that hopeless psychiatric residents are tolerated because they are "nice people," therefore must wish the best for their patients and therefore complete a residency which they should have never started and certainly never been allowed to finish. Palpably it never reaches completion, it just comes to an end. If being a "nice person" is the criterion for a given residency, then almost anyone qualifies for any residency since most medical students start off as "nice people," too many end up as greedy people.

Being a perpetual "nice person" dooms the psychiatrist to impotence. The psychiatrist who is not periodically threatened with death or dismemberment is a nice person and an ineffectual therapist. *There is nothing more inherently cruel than an exchange of truths and this is the business of psychotherapy.* Not a place for "nice guys." Those of us who have been around for a few years know this and are not much bothered. What does bother us is whether the Professor who has typically gone from residency to academic medicine knows this and can convey it to our young physicians who are mostly "nice people."

It is simple enough to generalize. It might be helpful to deal with a specific resident applicant. He is homosexual. The staff knows it. Potential fellow residents know it. The nursing staff, the secretarial staff, everyone knows it. So it is known. Few will openly criticize the staff for saying there is no opening for a resident this year, apply next year. Acceptable, except a lie. The applicant knows it. The staff and all the persons just mentioned know it and their compliance ought not be taken for granted.

If they know the applicant to be bright and competent, they may raise holy hell and ought not be taken for granted. There are other things to consider about this person. He is well liked. He was an exceptionally good student. He is bright. He is imaginable. He is at a young age, active in civic and church affairs. Accept him or reject him, don't lie to him. Discussion between staff is in order, it is essential to know whether his fellow residents will work with him and this may be approached too delicately. There is no need to inform the resident beyond clearings of the throat that Dr. X's sexual orientation differs from that of most.

The resident, for heaven's sake, probably knew this far in advance of the staff. The resident's acceptance seems the essential and determining factor. Given their acceptance and respect, there is no earthly reason to reject the doctor's application. Does one impose restrictions? Is he, for example, to be forbidden to treat another homosexual or, if so, to be accorded special

scrutiny? Absolutely not. The staff has the right to accept or reject. It does not have the right to append amendments. There the matter ends. We think. But if Associate Professor Y assumes to afford Dr. X particular attention, the residents will know. There is no more righteous rage than that of a righteously outraged resident. The system affords so few opportunities for the hunted to become the hunter that one happily assumes the offensive. The resident's moment.

A final word about Dr. X and his residency. Superficially and only superficially it may sound sensible to restrict his training in one narrow area. This is how sensible it is: it is neither more nor less sensible than telling a surgery resident that he may excise an appendix using his left hand only. Whether he is homosexual or not. Not at all incidentally, there are homosexual surgeons, internists, dermatologists, and so on and there is no particular reason to suppose any one specialty has either a monopoly or plurality or superiority.

Point, Counterpoint: Exchange of Ideas

If I am therapist and you are patient (Me, Tarzan, you, Jane), and you don't like me, tell me so. If you fail to do this, things may regress to the point that I have unwittingly done you irreparable harm. Be sure you really dislike *me*, not my tie, not an unrealized tendency to draw a bead on you with my pen or study your chart for a moment before saying anything. Annoying habits can be corrected even if I think you a jackass for finding them annoying. Give me a solid reason for your antipathy. Then we may resolve differences or we may decide that they are beyond resolution and part with no harm done, perhaps some help to you in selecting your next therapist. If you find me entirely too pompous or excessively humble or insistent that the hour is over when the buzzer sounds, we may truly be incompatible or we may be able to negotiate compromises. If my insistence on punctuality annoys you, we may settle this by asking whether you need medication refills or alterations at the beginning and seeing to this so that we have the remainder of our time for other purposes.

This sounds simple but it isn't because you may feel a need to discuss possible medication change in detail. But it is not insurmountable and it would require two morons to make it so. A few skirmishes over ground rules may be helpful because it establishes the humanity of both parties. There is actually only one unbendable rule. The treating person is and remains exactly that and the patient remains exactly that. The patient who fails to recognize this or refuses to do so has not recognized his position and would best depart the therapeutic scene until and unless he is ready to reenter.

This definitely does not rule out the difficult patient. The difficult patient is best described as . . . difficult.

The Paranoid may present as persecuted by his family, appearing reluctantly upon the advice of his friends who have told him/her that these friends benefitted from treatment and may still be doing so. It is quite in order to ask the patient entering treatment if he really feels himself in need of therapist's skills and the answer is usually an obvious yes.

Some are more skillful than others in persuading patients to enter therapy and we speak now of patients who definitely are in need of therapy. A few, no, a fairly large number of treating persons are in a sense playing a game, matching wits, bringing a patient into treatment then wondering why and how he is going to find the time to give the patient needed attention. To this therapist's credit, he will find the time or he will transfer the patient to another psychiatrist who has or can make the time. Such a transfer may be difficult or impossible since the patient may say, "You brought me into treatment when I was less than convinced that the treatment was necessary, you are now obligated." And the therapist is, he knows he is and he will find the time.

This can create an interesting situation. Imagine a reluctant, perhaps even sullen therapist dealing with a patient whose interest in treatment has been heightened. What a splendid time for the patient to create a moment and the therapist to respond. There is no assurance that progress will proceed without problems but even the possibility that the patient may be the one to say, "let's get on with it" is stimulating. The therapist may tell himself that he has committed an error which he will not repeat. His "error" is not an error in the usual sense, it is a sort of expertise without explanation, very much akin to Dr. F's unfallibility in discerning the presence of a tiny malignant breast nodule.

Barring a superior interpretation, it could be said that the infallible surgeon and the irresistible psychiatrist are the recipients of a gift that is God-given. It seems certain that such physicians exist, in rarity, but exist in every part of the world so one credits no particular Deity. Freud, the semi-athiest, could not agree. He would probably trace such a gift through a variety of teachers and, not given to intellectual modesty, conclude with himself. A semi-athiest is here defined as one who very much wishes that his commitment to athiesm is correct. Otherwise he is a dead duck.

The therapist who has lured a needful patient into treatment will do a good job. Initially he may modestly

attribute his gift to luck. Eventually experience, while not necessarily subduing modesty, will force him to admit to himself that he possesses something which his peers do not. It is not relevant whether he looks to the heavens or avoids cracks in the sidewalk. He knows he has a gift which he must use and shouldn't know how to rid himself of if he wished it so. He is a man for the moment but this does not eliminate the remainder of us. It may make us feel a bit stupid but we hope it does not diminish our determination and may increase our alertness.

Summary

We have searched for The Moment and its meaning. We have said, perhaps without sufficient emphasis, that it is not the property of any one medical specialty. We have all felt "this is something special, an understanding I have not known before and may not experience again." But we hope that one unique understanding may sensitize us to the next and still more to the next. While few, if any, can hope to reach a pinnacle of understanding which would place us among the gods, we can work. The harder we work, the more often we will know The Moment and the more frequently we know The Moment the harder we will work. We work for the good of our patients but honesty compels us to admit that we work to experience that minute fraction of time during which we can say "I have exceeded my own expectations and abilities."

We are aware of what the moment can never be. It is not a crystal ball. It is not a lucky charm. It will never be a *thing*, always a fraction of time during which some unbelievable but actual transaction between doctor and patient has taken place.

We recognize that there are sad moments but we also recognize that man is mortal and the time of sadness is inevitable for all of us. So we think of the miraculous and the wonderful and we feel both a sense of happiness and a sense of urgency to move on to our next private miracle.

Conclusion

A holy book offers much advice as to how to reach the moment. It also gives a warning, a stern one.

"It is good news and a warning: yet most men turn their backs and give no heed. They say 'that to which you call us cannot reach our hearts, for they are well protected. Our ears are stopped and a thick veil stands between us. Do as you please, and so will we. . . .'" *The Koran*. □

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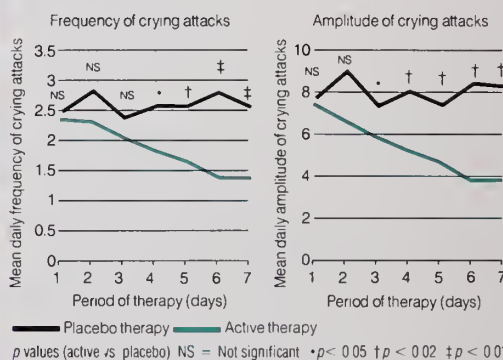
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¹ Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

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PZ24

Medical Information for Alabama Rural Physicians

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Abstract

Physicians practicing outside of Alabama's urban medical centers often have difficulty obtaining medical information for patient care. This article describes how Alabama's rural physicians may gain access to the biomedical literature needed for patient care using personal collections, communications technology, and libraries. A table in the paper lists health sciences libraries in the state which may provide consultative and information services.

Introduction

Ever increasing information needs have emerged that must be met if physicians are to provide optimal medical care. The need for medical information has forced a change in medical practice. "The knowledge of an information seeking process is critical to a physician's continuing education. . . ." "The duty to keep abreast is historically related to and limited by the locality rule, which sheltered rural physicians from keeping abreast of developments in the field at large. . . . Universal access to electronically-stored biomedical information could remove the last remnants of the locality rule from the standards of care in medical negligence suits."²

In this article, suggestions are offered to Alabama physicians on: 1) how to find information for clinical problem solving by developing and maintaining a personal office library; 2) how to use computers to access

the biomedical literature; and 3) how to use libraries and librarians as intermediaries to access the biomedical communications network.

The Information Needs of Alabama Physicians

In 1980, Stinson and Mueller³ reported on the information habits and needs of Alabama physicians. Four hundred two physicians were surveyed on their various sources of information. The medical literature was cited as the most common source of information. Professional colleagues were the second most common; information from association meetings was rated third and continuing education fourth. Unsolicited medical literature was used extensively, particularly by those in rural, solo practice. Recent studies⁴ support the fact that physicians scan journals as they arrive, but because the volume of journal literature is enormous and so difficult to manage, they rarely consult them later for solutions to specific clinical problems.

Haynes and colleagues⁵ point out just how enormous: they concluded that "if practitioners were to attempt to keep up with the literature by reading two articles per day, in one year they would fall 55 centuries behind. Put another way, if physicians were to read everything of possible biomedical relevance they would need to read 5500 articles per day."

The Haynes article is part of a series which gives physicians methods of effectively accessing and managing the volume of published literature.⁵⁻¹⁰ As a complement to current awareness reading, the volume of published literature necessitates problem-based research for clinical care.

Information for Clinical Problem Solving

When information for a clinical problem is needed, the most logical starting place is one's own collection. Basic and specialty textbooks are usually a part of most

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personal collections and are very heavily used. A core list of standard recommended texts and journals is published biennially in the *Bulletin of the Medical Library Association*.¹¹ This list and one published every three years by the American College of Physicians¹² enable physicians to update their personal book collections regularly. However, textbooks are quickly outdated and expensive to replace. Loose-leaf textbooks, such as *Scientific American Medicine*¹³ and other specialty loose-leaf services, are updated regularly and provide a convenient means for obtaining current information so necessary for patient care.

Although physicians have access to medical journals, scanning current issues is not an efficient way to locate specific information for a particular patient problem. Annual journal indexes, *Abridged Index Medicus* or *Index Medicus* can facilitate the location of articles on a clinical subject. Indexes provide access to a large number of journal titles covering longer periods of time. Recent technological advancements in data storage and retrieval have greatly improved access to the current medical literature.

Using telecommunications networks, the searcher accesses the computers at the National Library of Medicine (NLM), runs the search by combining a number of terms or subject headings to formulate a search strategy, and retrieves a bibliography in a fraction of time required to do a manual search using *Index Medicus*. Computerized bibliographic retrieval of medical information has put the National Library of Medicine within reach of every physician. More than 3000 journal titles from the medical, dental, and nursing literature are indexed in MEDLINE, which is international in scope.

In addition to MEDLINE, the medical community has access to HEALTH (Health Planning and Administration), PDQ (Physician's Data Query for cancer information), and many other data bases from the National Library of Medicine.

One of the most far reaching changes in computerized bibliographic retrieval is the development of end user search systems. GRATEFUL MED, a computer software package developed by NLM, brings MEDLINE directly into the physician's office. It is a user-friendly system which allows physicians to do their own searching. Personal computers are now more commonplace with many health professionals owning and using them for office management. GRATEFUL MED may be run on an IBM Personal Computer (or IBM compatible) with a Hayes (or Hayes compatible) modem.

The GRATEFUL MED program automatically connects to the National Library of Medicine computers through telecommunications networks, enters the user's identification code and password, runs the search which the user previously entered, and logs off the computer.

Abstracts of many articles are available on line and may provide solutions to clinical problems, eliminating the need to retrieve the full article. Also available on the new version 4.0 of GRATEFUL MED are CATLINE (books cataloged by NLM), DIRLINE (a directory of organizations), PDQ (cancer database), and a number of other databases. Although NLM has been in the forefront of computerized bibliographic retrieval, there are other vendors of database services and end user search systems.

MEDLINE and other health related databases are available through DIALOG, BRS, AMA/NET, and others. Several vendors offer databases which include the full-text of a number of journals and books. MEDLINE is now available on CD-ROM (compact disk) as a subscription from several vendors. The software packages developed by each vendor to access the MEDLINE database make each product substantially different. Rather than paying telephone connect charges and on line fees to access remote databases, the user leases the disk. MEDLINE on CD permits unlimited on-site access with no further charge.

Using Libraries to Obtain Medical Information

Physicians can use a health science library to extend their personal collections and as an alternative to personally searching online databases for medical information. A selected list of Alabama health sciences libraries is included as a table in this article. The health science library should have a current, authoritative collection which includes textbooks, journals, and journal indexes. Although the library may not have all the resources required, the librarian will be able to obtain many of them by placing an inter library loan request to another library. Current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards require hospitals to provide library services, including the services of a "qualified medical librarian or the regular consultative assistance of such an individual."¹⁴

There are several advantages to the physician in contacting their affiliated hospital or the nearest hospital with a medical library for information services. Many hospitals which have libraries consider online literature searches and photocopies to be value-added services, whether or not the requesting physician is affiliated with the institution. Any contact with a physician, including contact for an information service, is a potential patient referral point for hospitals within its catchment area.

Services may be provided to the requester at no charge or at a reduced rate; services may be considered as a professional courtesy or an incentive for referring patients to that hospital or to hospital affiliated physicians. Frequently, the hospital will have a toll-free physician referral line which may be used to request

information services. If the postal service is used for document delivery, mailing locally may be quicker than from long distances.

If telefacsimile is used for document delivery, local phone costs are less than dialing long distance. Utilizing the local hospital's library collection encourages the institution to further develop or otherwise improve the resources available on site. In spite of JCAHO standards, the reality of Alabama's health care economics is that some rural hospitals may not be able to provide adequately equipped and staffed libraries. Physicians must use other means of obtaining MEDLINE searches and copies of articles when they do not have needed materials in their personal collections and when their affiliated institutions can not fully meet their needs.

There are well established avenues in Alabama for obtaining information services regardless of the physical location of the physician. If there is no locally available hospital-based library, the physician's only option for obtaining searches and articles may be to contact the state's academic medical center libraries. Alabama's academic medical center libraries will provide services directly to the state's health professionals, but in general, fees are charged for online literature searches and photocopies.

Conclusion

This paper presents a brief overview of methods by which Alabama physicians may obtain medical information using traditional and technologically advanced means. A table lists health sciences libraries throughout the state. These libraries may be contacted by physicians for assistance with their information needs.

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Selected Alabama Health Science Libraries

BIRMINGHAM

AMI Brookwood Medical Center Medical Library	Contact Person: Lucy Moor, Medical Librarian Phone # 877-1131
Baptist Medical Center Princeton Medical Library	Contact Person: Maureen Battistella, Medical Librarian Phone # 783-3078
Carraway Methodist Medical Center Medical Library	Contact Person: Bobby Powell, Medical Librarian Phone # 226-6265
Medical Center East Medical Library	Contact Person: Virginia Ferrel, Manager Phone # 838-3393
University of Alabama at Birmingham Lister Hill Library of the Health Sciences	Contact Person: Virginia Algermissen, Director Phone # 934-5460 or MIST 800-292-6508

DOTHAN

Southeast Alabama Medical Center Medical Library	Contact Person: Pat McGee, Director Phone # 793-8102
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GADSDEN

Baptist Memorial Hospital Medical Library	Contact Person: Paula Davis, Librarian Phone # 543-4128
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HUNTSVILLE

University of Alabama at Huntsville School of Primary Medical Care Library	Contact Person: Lee McCann, Director Phone # 536-5511
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MOBILE


University of South Alabama Biomedical Library	Contact Person: Robert Donnell, Director Phone # 460-7043
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Auburn University at Montgomery AUM Library	Contact Person: William Petas, Dean Daniel Blucker, Reference Phone # 271-9445
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ALABAMA — Assistant Professor of Pediatrics needed. The University of Alabama in Huntsville, School of Primary Medical Care and Huntsville Program of the University of Alabama School of Medicine. Pediatrician with competence in teaching medical students and residents. Training or interest in pediatric pulmonary medicine or pediatric intensive care desirable but not necessary. Should be board certified or eligible. Submit C.V., including bibliography and names of three references to: John R. Montgomery, M.D., Chief of Pediatric Programs, School of Primary Medical Care, 109 Governors Drive, Room 205, Huntsville, AL 35801. Phone: (205) 551-4443. The University of Alabama in Huntsville is an affirmative action/equal opportunity institution.

GEORGIA: Emergency Department Directorship. Immediate opportunity for experienced emergency physician in low volume, smaller community hospital. Position combined administrative and clinical responsibilities. Competitive compensation includes director's stipend and complete benefits package with professional liability insurance procured on your behalf. Contact: David Biggs, Coastal Emergency Services of Augusta, Inc., 519 Pleasant Home Road, Dept. SSF, Suite C-1, Augusta, GA 30907; (800) 868-2627 or (404) 868-0185.

GEORGIA — Directorship available in emergency department of St. Francis Hospital in Columbus, GA, second largest city in Georgia. Volume of 18,000 a year, but most trauma goes to Medical Center. Must be BE in IM, FP, or EM. Total package in excess of \$100,000. Call or send CV to Kathy Hurley, Coastal Emergency Services of Atlanta, Inc., 1900 Century Place, Dept. SF, Suite 340, Atlanta, GA 30345 (800) 333-3637.

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Impaired Physicians — We Can Help!

The American Medical Association has defined the impaired physician as one who is unable to practice medicine with reasonable skill and safety because of mental illness or excessive use or abuse of drugs, including alcohol. Please read this with one other group in mind — the physician who has been sued, and his family!

Physicians are no different from other people in experiencing the difficulties in life that can lead to impairment. In fact, the characteristics physicians often develop to adapt to the extreme stresses involved in the training and practice of medicine may put them at special risk for this problem.

This is discussed quite well in a pamphlet published by the American Medical Association Auxiliary entitled "What Every Physician's Spouse Should Know . . . Impairment," which states: "The process of training physicians can be like an endurance test. The demands for the profession are so great that trainees may feel overworked and overstressed. To succeed, medical students and residents may become obsessed with work, self-sacrificing, highly competitive, and outwardly unemotional. . . . These intense pressures on medical students and residents can leave them with little time or energy for personal relationships or other life-enriching experiences, a factor that alienates them from society.

"Once physicians begin to practice, stresses and behavior patterns tend to stay much the same. Excessive time demands still exist or may increase, with pressures to keep up with patient care and with new technology and medical advances. Physicians feel required to suppress emotions toward their patients and to distance themselves from death. They also continue to feel pressure over whether they have provided the proper treatment for difficult cases.

"In addition to these continual stresses, other frustrations occur for physicians after they begin practice. During the training years, physicians may have dreamed about the independence they would have. Yet once in practice, many become disillusioned when they find that the independence does not really exist, particularly today with constraints from the government and third-party payers.

"The marriages and family lives of physicians may be adversely affected by the demands of the medical profession. Too little time at home may make it difficult for them to maintain successful relationships with family members. This may be especially true for those who are compelled to use time at home to do paperwork or catch up on their reading of medical journals. The promises of what can be bought with the money that results from the physician's hard work will not

replace the love and involvement family members want and need.

“When physicians bring home the autocratic sense of authority that is often used in the office, family members may resent being treated like patients and being told what to do. Physicians may also strain marital relations in other ways. They may postpone or cancel family outings and vacations due to work demands or expect spouses to handle all household problems because of their concerns with the medical practice.

“A lack of fulfillment may develop in physicians who have been in practice for some time. Physicians go into practice with the ideals of saving lives and making great contributions to the community and sometimes it is difficult for them to accept the everyday, routine work that is a part of a medical practice. These physicians may start to question whether all of the hard work has been worth it and may feel a sense of emptiness and failure.

“The demands of medical practice cause physicians to experience numerous pressures throughout their careers and to deny many of the human needs for social and family interaction. These pressures and deprivations can cause anger, anxiety, fear, and stress — factors that may lead to mental illness, and/or drug and alcohol abuse in some physicians.

“Alcohol or drug abuse may have begun as early as the training years as a way to cope with the stress. Physicians are especially at risk for drug abuse — and not just because of their easy access to drugs. As medical students, they are trained to use medication to solve patients’ problems and they may come to view drugs as an easy and appropriate way to solve their own problems as well. Also, because of their medical training, physicians may feel that they are knowledgeable enough to control drug use without becoming addicted.

“Obviously, ALL physicians suffer from stresses that can lead to impairment. Yet not all physicians become impaired. If physicians are aware of the inherent risks of impairment in the medical profession and employ certain coping mechanisms, the pressures are less likely to result in impairment.

“Some of the coping mechanisms recommended for all physicians include:

- establishing good communications and intimacy with spouses, children, and friends so that a solid support system can be established for coping with life’s pressures;

- leaving medical concerns at the office or hospital so that physicians can experience quality time with family and friends;

- ensuring successful family interactions by taking 30 minutes to decompress from office pressures before getting involved in situations at home;

- learning to manage time and define goals so that

physicians can be involved with one activity without worrying about other responsibilities;

- cultivating outside interests or hobbies that are fun, not work, so that medicine does not become so all-consuming;

- taking care of personal health by getting plenty of exercise, eating properly, and avoiding excess use of alcohol, tobacco and caffeine.

“Impaired physicians may exhibit behaviors in certain areas of their lives that will serve as clues that a problem exists. These may occur in sequential progression, or simultaneously. Spotting the warning signs is important. The earlier impairment is identified, the sooner physicians can begin treatment and the better their chances for complete recovery.

“Community activities are the first area of life in which warning signs of impairment can be noticed. Impaired physicians may exhibit unpredictable behavior at social functions or they may be arrested for drunk driving. They may also withdraw completely from community involvements, contacts with colleagues and friends, continuing medical education, or medical society activities.

“Next, physicians will begin to develop problems within the family, through withdrawal, unexplained absences from the home, or fights in which they may lay all of the blame on their spouses and children. Impaired physicians may go on reckless spending sprees, placing the family in financial difficulties. Or they may develop sexual problems such as impotence or extra-marital affairs.

“At this point, the physical state of impaired physicians will start to deteriorate. This may be exhibited through poor personal hygiene, dressing habits, poor physical health with multiple complaints of health problems and the use of numerous prescription drugs.

“The physician’s employment record is the next area of life which may become affected. If a physician is in a group practice, he or she may complain that the partners are causing problems and will then switch to a solo practice. Impaired physicians may often relocate geographically, moving to another part of the country to start over.

“When impairment shows up in the workplace, behavior in both the office and hospital will change markedly. Impaired physicians may disrupt their patient schedules, treat both the staff and patients with hostility, or have frequent absences from the office. At the hospital, impaired physicians may make rounds late and give inappropriate orders.

“Generally, impaired physicians do not voluntarily seek help. As with most impaired individuals, physicians will usually deny that a problem exists. As medical practitioners, they may feel knowledgeable enough to identify and handle any problems that are seriously affecting their health or lives. They do not like to be patients. This is caused, in part, by the image

patients have of physicians — that they are strong and never get sick. To maintain this image, physicians feel pressure to deny illness and will not allow themselves to seek help.

“Impaired physicians are also afraid of what may happen to their careers if they seek help. They fear losing their patients, status in the community, financial security, and most importantly, their license to practice medicine.”

And this is where we all can help! Alabama is fortunate to have the Alabama Impaired Physicians Committee, composed of physicians from all over the state. This Committee is non-punitive, confidential, and performs in an advocacy role for the impaired physician. The Physician Help Line number is (205) 263-3947, and the desire of each committee member is to help impaired physicians as early as possible, to prevent harm (mental and physical) to physicians’ families and patients, and to prevent loss of medical licenses. Chairman of this committee is William J. Tally, M.D., Fairhope, AL (928-0502), and committee members are C. Neal Canup, M.D., Anniston (237-5370), Pete Cox, M.D., Florence (764-5351), Charles W. Daniels, M.D., Mobile (433-6942), Harrison M. Goodall, M.D., Northport (53-3760), William H. Goodson,

M.D., Huntsville (880-7350), Charles E. Herlihy, M.D., Birmingham (591-3451), William Jerry Howell, M.D., Prattville (365-6949), B. Dowling Petrey, M.D., Ozark (774-5182), Carl B. Shory, M.D., Birmingham (595-4247), and George D. Oetting, Ed.D., MASA Staff Helper (1-800-392-5668 or 263-6441). Please call one of these or the Help Line phone if you think you need help!

A truly impaired physician is a terrible loss to all of us — to the physician’s family, to the community, and to the health system. We have much invested in each physician in terms of love, schooling, time, instruction, and money. We need every physician to be able to function as a caring person, and one cannot function if alcohol abuse, drug abuse, or mental or physical illness is present. A-MASA is hoping to establish a Spousal Committee to be available to help, even if only by listening. Remember, help is as close as your telephone, and is non-punitive and confidential!

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Coronary Angioplasty in Acute MI

Silvio E. Papapietro, M.D., Joaquin G. Arciniegas, M.D., Michael T. Simpson, M.D., Alfred W. H. Stanley, Jr., M.D., Randall G. Hess, D.O., Terry B. Cooper, M.D., William A. H. MacLean, M.D., William J. Rogers, M.D.*

The Thrombolysis in Myocardial Infarction (TIMI) II Trial has been completed and the results reported at the 61st Scientific Sessions of the American Heart Association in November of 1988, and published in the *New England Journal of Medicine* in March of 1989.¹ The results of this NIH sponsored Trial will exert considerable influence in the treatment of patients with acute myocardial infarction. We were privileged to participate in the TIMI Trial as co-investigators for the University of Alabama Medical Center at Birmingham. Part 1 of this article will summarize the results of TIMI II. Part 2 will evaluate the role of percutaneous transluminal coronary angioplasty (PTCA) in some subsets of patients with myocardial infarction not included in TIMI II, review some controversial and unresolved issues, and present our current approach to the management of acute myocardial infarction.

Part 1

Timely thrombolytic therapy can recanalize occluded coronary arteries, limit infarct size and reduce mortality in acute myocardial infarction. However, early reocclusion of the infarct artery has been felt to be a persistent problem, and reportedly occurs in 15 to 25% of patients, particularly those with a severe residual coronary stenosis. In an effort to prevent reocclusion of the infarct artery, it had become common practice in many cardiovascular centers, including our own, to carry out coronary arteriography soon after thrombolytic therapy and if a residual stenosis in the infarct artery is identified, to perform PTCA prophylactically in these patients. However, the benefits and risks of this approach had not been clearly identified.

The TIMI Trial was designed to evaluate the potential benefits and optimal timing of PTCA after thrombolytic therapy for acute myocardial infarction. The Trial was performed at 24 sites in the United States, and recruitment occurred in 50 hospitals. A total of 3,262 patients were entered into the trial between April of 1986 and June 5 of 1988. Patients had to be less than 76 years of age, with at least 30 minutes

of ischemic chest pain and electrocardiographic changes of transmural myocardial injury. Those patients considered high risk for hemorrhagic complication from thrombolytic therapy were excluded. Thus, patients with cerebrovascular disease, arterial hypertension, recent surgery, major trauma, gastrointestinal bleeding and prolonged cardiopulmonary resuscitation were excluded. Patients with previous coronary bypass surgery or left bundle branch block (that prevented adequate interpretation of the electrocardiogram) were also excluded. All patients entered into the trial received tissue plasminogen activator (r-TPA) within four hours from the onset of symptoms. The initial 520 patients received 150mg of r-TPA over six hours, but because of a high rate of intracranial hemorrhage previously reported,² the r-TPA dose was reduced to 100mg in the last 2,742 patients. A substudy (TIMI-IIA) was incorporated into the trial design to determine whether immediate cardiac catheterization and PTCA (within two hours from r-TPA) would confer an advantage over the same procedures performed 18-48 hours later. The TIMI-IIA substudy³ demonstrated that cardiac catheterization and PTCA within two hours from initiation of r-TPA therapy was associated with increased bleeding complications and a greater need for coronary artery bypass surgery, without any demonstrable benefits when compared to the procedures performed at 18-48 hours. The results of TIMI-IIA were similar to those reported by the Thrombolysis and Angioplasty in Myocardial Infarction (TAMI) Study Group,⁴ and the European Cooperative Study Group⁵ that also found a significantly increased mortality rate when PTCA was performed in the presence of r-TPA. From these studies, most investigators now agree that routine prophylactic PTCA performed immediately after onset of symptoms of acute infarction and during administration of r-TPA offers no advantage, is less likely to be successful, and carries a higher risk than deferring the procedure beyond 18 hours from onset of symptoms and therapy with r-TPA.

The main objective of TIMI-II was to compare two strategies following thrombolytic therapy. An "invasive strategy" which consisted of routine coronary arteriography 18-48 hours after r-TPA followed by prophylactic PTCA of the infarct artery if the anatomy was suitable, and a "conservative strategy" which consisted of conventional care following r-TPA, with

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coronary arteriography and PTCA only with recurrent spontaneous or exercise induced myocardial ischemia. Cardiac catheterization and prophylactic PTCA, when feasible, were performed routinely in all patients randomized to the invasive strategy. In patients randomized to the conservative strategy, coronary arteriography and PTCA were recommended only in the presence of recurrent spontaneous ischemia or a positive exercise test (defined as exercised induced angina, electrocardiographic changes of subendocardial injury, or an abnormal reduction in left ventricular ejection fraction by radionuclide ventriculography). In patients who underwent PTCA, the procedure was limited to the infarct related artery. To insure PTCA experience and proficiency, angioplasters were required to have performed personally at least 100 angioplasties with a mortality rate below 2%, and a success rate above 85% in the most recent 50 cases.

The randomization process resulted in no significant difference between the two strategy groups. Most patients were male (82%), and middle aged (mean 57 years), and two-thirds were considered "high risk" (defined as age greater than 70 years, acute anterior myocardial infarction, or a previous myocardial infarction). Average time from onset of chest pain to treatment with r-TPA was approximately two hours and 40 minutes in both groups. Among the 1,676 patients randomized to the invasive protocol 1,461 underwent catheterization according to protocol at a mean of 32.5 hours from randomization, and 85% had a patent infarct artery at this time. Cardiac catheterization was also performed on an emergency basis before this time in an additional 66 patients because of recurrent myocardial ischemia. Thus, cardiac catheterization was carried out by 48 hours after randomization in 93% of the patients in the invasive strategy. In the 7% of patients that did not have cardiac catheterization in the invasive strategy group, this was not performed because of death, bleeding or hemodynamic instability, or refusal by patient or physician. PTCA was performed in 60% of the patients in the invasive strategy with a success rate of 93%. PTCA was not performed in 40% of the patients in this group because there was no lesion of up to 60% in the infarct related artery (13%), the lesion was complex and unsuitable for PTCA (13%), or the infarct artery was occluded at the time of cardiac catheterization (12%). Among the patients randomized to the conservative strategy, 26% experienced a recurrent ischemic event within 14 days, 13.5% underwent PTCA in the first 14 days, and 16.8% by 42 days. The success rate of PTCA at 14 days was 92%. Coronary artery bypass surgery was performed in 11.9% of patients in the invasive strategy and 10.5% of patients in the conservative strategy by 42 days of followup.

The primary end-point of TIMI-II was death or myocardial infarction at 42 days. In the invasive strategy,

mortality was 5.2%, fatal or nonfatal reinfarction 6.4%, and death or reinfarction 10.9%. In the conservative strategy, mortality was 4.7%, fatal or nonfatal reinfarction occurred in 5.8% of the patients and death or reinfarction in 9.7%. The differences between the two strategy groups were not significant.

A positive exercise test at hospital discharge was observed in 10.8% of the patients in the invasive strategy, and in 17.7% ($p < 0.001$) in the conservative strategy. Resting left ventricular ejection fraction at six weeks was similar in both groups, and averaged approximately 50%. Among the patients in the conservative strategy, 370 who experienced recurrent ischemic events underwent cardiac catheterization and PTCA mandated by symptoms. The mortality in this group was only 3.3% at 42 days, demonstrating that in patients who developed recurrent ischemia, cardiac catheterization and PTCA were associated with an excellent outcome and low mortality.

To this date, approximately 50% of the patients have reached one year of followup, with a remarkably high survival rate of 93% for both invasive and conservative strategies. These data are particularly impressive if one considers that more than 50% of the patients belonged to a "high risk" category.

The two strategies tested in TIMI II led to excellent results. Mortality was only 5% at six weeks, and approximately 7% at one year. The low mortality observed in TIMI-II may be related to the combination of early therapy with r-TPA, together with Heparin and followed by aspirin, as well as aggressive medical management and the use of urgent PTCA when required. The invasive and conservative strategies were similar in mortality, a recurrent myocardial infarction, and resting left ventricular ejection fraction. The invasive strategy was associated with a slightly greater increment in exercise left ventricular ejection fraction at six weeks, and a slightly lower incidence of exercise induced ischemia at hospital discharge.

A substudy of the TIMI-II Trial involved the determination of the effects of early versus deferred administration of metoprolol, a relatively cardioselective beta adrenergic blocking agent, in eligible patients. Because this group was small, the primary end-point was radionuclide left ventricular ejection fraction, and not mortality. Eligible patients were randomized to receive 15mg of intravenous metoprolol immediately after commencement of the r-TPA infusion, followed by oral metoprolol, or to deferred beta blocker therapy with metoprolol initiated orally on the sixth hospital day. The mortality at 42 days in these two groups was extremely low, 3.7% for the early beta blocker group, and 3.6% for the deferred beta blocker group ($p = \text{NS}$). The group treated with early beta blockers had a significantly lower incidence of recurrent ischemic events (15.4% versus 21.2%, $p = 0.005$), and a trend towards

a lower incidence of recurrent myocardial infarction (4.3% versus 6.3%, $p=0.09$).

Probably the most important finding of TIMI-II was the excellent outcome of patients with acute myocardial infarction treated with r-TPA, Heparin and aspirin, with cardiac catheterization and PTCA performed only in those with recurrent ischemia. The study demonstrated that routine cardiac catheterization post infarction and prophylactic PTCA of residual stenoses in the infarct artery is not associated with a better longterm prognosis. The 93% survival rate at 12 months in both strategy groups indicated that the risk of reocclusion, reinfarction and death are small, and less than previously anticipated. It should be emphasized that TIMI II has not demonstrated that PTCA is not necessary in the treatment of acute myocardial infarction, but should be mandated by recurrent ischemia rather than performed prophylactically in all patients with post infarct residual coronary stenoses. The value of PTCA performed in the presence of recurrent ischemia was demonstrated by the high success rate and excellent outcome in the 307 patients in the conservative strategy who underwent PTCA.

It is resonable to conclude that patients with acute myocardial infarction, similar to those entered into the TIMI II Trial, may be treated with r-TPA, Heparin and aspirin, with cardiac catheterization and PTCA reserved for those with recurrent myocardial ischemia,

either spontaneously or exercise induced. The findings of this Trial do not support the practice of routine cardiac catheterization and prophylactic PTCA of residual stenoses in patients without evidence of ischemia post infarction. □

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Warnings: Angioedema. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hypotension, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: General: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucoside, nitrates, calcium-channel blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, furosemide, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters. There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that

show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC[®] (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome: inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactively following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension), cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis, stomatitis.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Herpes zoster, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity rash and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: Hypertension. In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance <30 mL/min (serum creatinine >3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d. then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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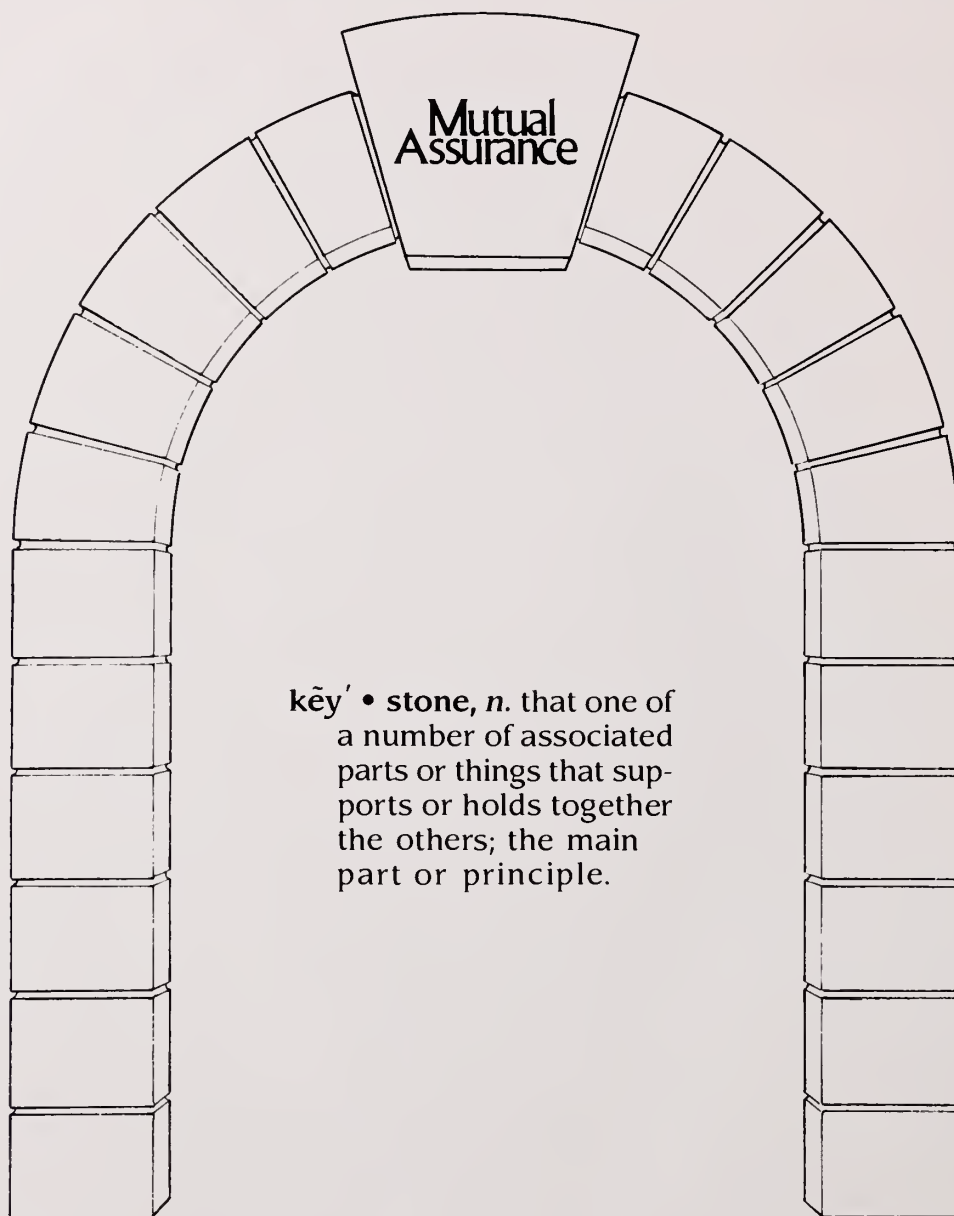
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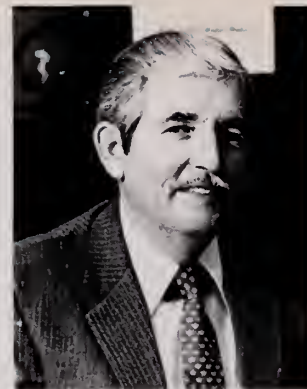
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S. Lon Conner
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False Gods

As this is written, news pictures before me record the ignominious displacement of the 25-foot-tall statue of Lenin from its 30-year position of idolatry in Sincteia Square, Bucharest, Romania.

Hoisted by the neck with a steel cable, Lenin swung slowly in the wind before being deposited supine before the jeering multitude, symbolizing the failure of Marxism in Europe almost as well as the demolition of the Berlin Wall.

All the old icons of the false gods are being swept away by the furious winds of freedom. In the Soviet Union itself, frenzied reform and the admission of the failure of socialism/communism signal the dawning of a day that virtually no one, no matter how learned, had predicted. Even in Nicaragua, the people surprised the pollsters, to whom they had apparently lied, by throwing out their Soviet-leaning government.

These epochal events stagger the mind. We are privileged to witness a worldwide repudiation of a demonic civil religion, a pseudo-science that for all these years professed to explain everything and to be the answer to all human aspirations and needs.

Thousands of educated and well-meaning but deluded men and women in the free nations of the West embraced the catechisms of Marx and Lenin in the years between the great wars, believing that socialism/communism offered the best hope for man.

It was all so simple: if all resources were owned in common; if the benign state itself determined the destiny of the people, taking from each according to his ability to provide, and giving to each according to his needs, then the blessings of collectivism would descend evenly over the masses.

In 1973, the logician Imre Lakatos sought to demonstrate the difference between science and pseu-

doscience; how science has its own internal mechanisms for self-correction of error. He used the simple example of Newton's three laws of mechanics and the law of gravitation, constantly being challenged and tested by the problem-solving machinery of science, which also permits predictions of hitherto unknown events.

He used Marxism as his example of the exact polar opposite of science: "In degenerating programs, theories are fabricated only in order to accommodate known facts." Upon such contrived premises Marxism made its scientific predictions:

"It predicted the absolute impoverishment of the working class. It predicted that the first socialist revolution would take place in the industrially most developed country. It predicted that socialist societies would be free of revolutions. It predicted there would be no conflict of interest between socialist countries.

"Thus the early predictions of Marxism were bold and stunning, but they failed. Marxists explained all their failures: they explained the rising living standards of the working class by devising a theory of imperialism; they even explained why the first revolution occurred [not in the most advanced industrial society, but] in industrially backward Russia. They 'explained' Berlin 1953, Budapest 1956, Prague 1968. They explained the Russian-Chinese conflict.

"But their auxiliary hypotheses were all cooked up after the event to protect Marxian theory from the facts. The Newtonian program led to novel ideas; the Marxian lagged behind the facts and has been running fast to catch up with them."

It didn't run fast enough, as the counter-revolutions of 1989-90 demonstrate so convincingly. Watching all this from the security and complacency of the United States, we are being sharply reminded

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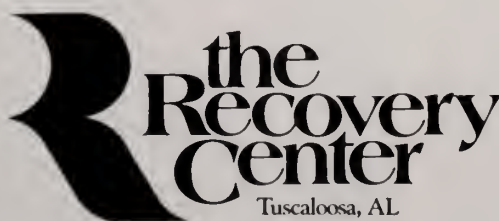
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almost daily of the freedoms we have long taken for granted.

There is, for example, an object lesson for American physicians in the mass exodus of doctors from East Germany since the wall was breached. And there might well be much deeper lessons: as physicians in Eastern Europe flee the precepts of Marxism, some of these same precepts are insinuating themselves into American health care.

Under the impetus of a vast federal medical program, even the private sector has moved rapidly toward embracing central command & control that smells of pure Marxism. The militant program of medical reductionism now underway is praised by opportunistic politician and pious pundit alike. We are feverishly reducing American health care to numbers, guidelines, integers and parameters, the very kind of statism that Marxism predicted would balance the needs of the masses with the collectivized resources of the providers—from each according to his ability, to each according to his needs; the great equalizer; the golden common denominator now toppled from the square in Bucharest and at Brandenburg Gate.

We have before us an enormous American social experiment in codifying and digitizing human illness and healing into “user friendly” software that will enable a semi-literate claims adjuster to believe he/she is smarter than the physician being reviewed. From the shrine of a computer terminal connected to an 800 number, this instant expert will know what is best for a patient, now no more than numbers on the cathode ray tube, as is the disease process and the physician fighting it.

But, the defenders of digitized New Math medicine say, we are in an extreme emergency; health care is out of control. Much the same thing was said in Eastern Europe 40 years ago. And the socialist groups that formed in the major cities of the United States during the Depression said American democratic economics had failed and must be replaced by the benign tyranny of a kindly socialist state.

In Germany during the 1930s the Nazi's brand of socialism was sold to the people as the extreme therapy necessary to cure the economic ills of the old and discredited Weimar Republic.

Emergency conditions have always been used by usurpers to rationalize their brand of pseudoscience. And the emergencies are prolonged, decade after decade, until, in their desperation, the people tear down all the idols of the Marxist pantheon.

There are many lessons large and small in the news from the old capitols of Europe. I wonder if this country will heed them. For Americans these lessons should form a dramatic refresher course in the basic

freedoms that are the true warp and woof of our society.

It has been a long time since most of us thought about all the values of liberty now being enunciated anew in Eastern Europe. As they discover the fundamental liberties guaranteed in our Bill of Rights, it would be well if we would forswear our complacency and superiority and reflect on each of them under the spotlight of their discovery.

We could then re-live, in some measure, the progress of our own democracy from its turbulent wellsprings. We could learn anew what freedom of speech means; we could better comprehend freedom of worship; petitioning for redress of grievance; freedom of assembly; the right of trial by jury; freedom to come and go as we jolly well please; freedom to choose from the vast offerings of our many marketplaces.

In the process of our own rediscovery, we Americans may experience an epiphany in regard to still another cherished freedom now undergoing rapid corrosion in our own land—the freedom to choose our doctor and to authorize him/her as our advocate, to determine what course of care is best for us as individuals, not as some computerized norm, average, or diagnostic grouping.

Somehow, U.S. medicine must make the public understand that when the physician's authority is circumscribed and diluted by the fiat of reviewers, it is the patient who suffers most. In the present climate many Americans may condone all manner of restrictions on doctors, but they must understand that physician liberty vitally impacts on their own liberty, their well-being and indeed their very lives.

To believe, as too many Americans seem willing to do, that physicians can be hogtied without damage to patient care is nonsense, dangerous nonsense.

Ask any of those in Eastern Europe now getting their first whiffs of freedom. Ask them about the quality and quantity of care they received when the state dictated both.

Here in 1990, Americans have the unprecedented opportunity to re-live the evolution of their own freedoms through study of a similar process going on in Europe.

Many, many thousands of our predecessors gave their lives on distant and forgotten battlefields to assure these freedoms. Their sacrifices, like the rest of the history of this republic, are largely forgotten, or never known by our increasingly uneducated population.

The breaking out of freedom in Europe, the greatest event of its kind in the history of the world, should not be simply a diverting spectacle for bored Americans, but the unique opportunity to be transported back to our own 18th century and to witness this country's birth in real time on the nightly news. □

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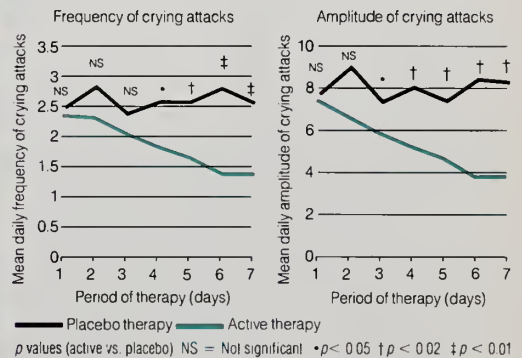
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¹ Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508



*Burt Taylor, M.D.
President, MASA*

Etched In Stone

The men and women of the medical profession are not paranoid. Big Brother really is looking over your shoulder and is preparing to open a potentially negative file just for you. Big Brother's gaze is more penetrating and disturbing than at any time in the past. The National Practitioner Data Bank is scheduled to become operational in April or May 1990. Once this process begins it appears that it will become a part of a physician's curriculum vitae and might affect his medical career significantly. Hospital staff privileges and all other credentialing groups will probably query the Data Bank as the first step in considering an application from a practicing physician. As with any other government bureaucracy the opportunity to control this monster, once it has been created, will be extremely limited. I have recently listened to an indepth discussion of the Data Bank and I feel that it is very important for the physicians of Alabama to understand this process. I hope you will take the time to read this article this month.

As the competition for hospital staff privileges becomes more intense the information in your Data Bank will become critical in the future. We must be very observant and carefully review any letters which we receive from the Data Bank. Each physician should directly defend any attempted sanctions at the local or state level prior to the activity being concluded and before it is reported to the Data Bank. Once an entry has been made in the Data Bank it cannot be removed.

Significantly, the exact date that the Data Bank activities will commence has not been determined.

Again, the target date is April 1990 but it may be delayed for another few weeks or even months. Each physician will begin with a clean slate. No previous actions will be entered into the Bank; however, the determining factor will be the date that a malpractice payment is made. If a case has been pending for several years and the payment is made after the Bank has opened, that will be entered into the Data Bank. Any action that is paid by check prior to the opening of the Data Bank will not be included in that physician's file.

Where did the idea for a Data Bank originate and why will it add to the overwhelming stresses for the actively practicing Alabama physician? It was supposedly enacted because Congress found "growing evidence" of medical malpractice and the need to improve quality of care. Public Law 9965, the Health Care Improvement Act, was enacted in November 1986. The Law creates the Data Bank for the Secretary of Health and Human Services to be utilized to report and disseminate data on practitioner's discipline as well as professional liability judgments. The Law affects licensing boards, all hospitals, other health care entities, professional liability insurers and the various professional services.

Title 4 of the Act has two distinct components.

The first component established immunity for physicians and professional review bodies. The second component of the Act established a Federal data bank called the National Practitioners Data Bank (NPDB). Its stated purpose is to provide a central clearinghouse of information aimed at preventing less than competent

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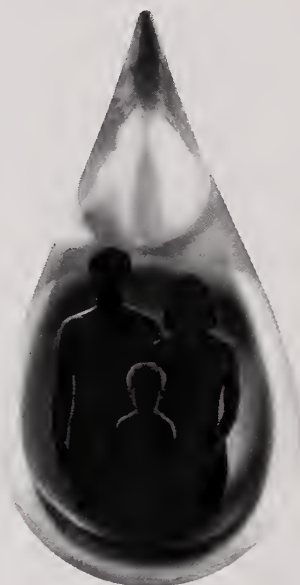
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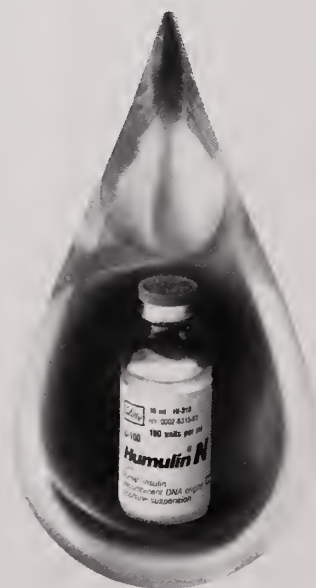
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Hospitals and other health care entities are required to check the Data Bank when considering an application for clinical privileges whether these be courtesy privileges or active staff. The hospital must query the Data Bank regarding its staff members every two years. On request NPDB information will also be released to state licensing boards and to qualified health care entities. In addition, a physician or other practitioner is entitled to access his or her own NPDB record at any time.

Since its inception in 1847 the AMA has been dedicated to improving the quality of medical care. Through

the use of the AMA physician master file and a long-standing working relationship with the Federation of State Medical Boards the AMA disseminates information on State Medical Board actions through this profile service and sends monthly alert letters to every state where a sanctioned physician has ever held a license. Thus, the AMA supported the enactment of the Health Quality Improvement Act of 1986.

In June 1986 the AMA House of Delegates adopted Report QQ, the AMA initiative on Quality of Medical Care and Professional Self-Regulation. This report outlined the key AMA objectives including expansion of the physician master file. The file included actions taken by hospitals, those actions that restricted the privileges of a less than competent physician, and in turn, developed a mechanism for removing physicians guilty of misconduct or incompetence from AMA membership roles. Therefore, as a natural extension of the initiative outlined in Report QQ, the AMA, in partnership with the Federation of State Medical Boards, submitted a proposal to operate the Federal Data Bank under contract of the health Resources and Services Administration which is a component of the Department of Health and Human Services. Due to the lack of funding the original request for this proposal was withdrawn and a new one was issued in 1988. The AMA and the State Federation of Medical Boards chose not to resubmit their original

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proposal. In December 1989, a 15.9 million dollar contract was awarded to the Unisys Corporation in order to establish and operate the Data Bank under the direction and guidance of the Federal Government. Dr. Daniel Cowell is a Board certified psychiatrist. He is a member of the AMA and has been given the responsibility to lead the Federal team that is to implement the Data Bank. Dr. James Todd, AMA's acting Executive Vice President, was appointed to the NPDB Executive Committee and has oversight over this project. Dr. Norman Buddy, director of the division that manages the AMA physician master files, serves on the Technical Advisory Group. In this way, the AMA is able to represent the concerns of its association and its members.

In June 1989 the department was requested to add research data elements to Title 4 to enrich the data base for "medical malpractice research." Dr. Cowell convened a group of six experts who were already performing research in this area in the United States. This group developed a list of additional elements that will be "put out for public comment later this Spring." Regulations on Title 4 were published in October 1989. Conferences regarding the Data Bank were begun in February 1990. There will be four major conferences for hospital administrators and chiefs of staff around the country. They will be held in Atlanta, Washington, St.

Louis, and Los Angeles. The conferences for the explanation of the Data Bank to the medical malpractice insurers and for the state association medical boards have been completed.

It should be obvious to all of us that this legislation will take on greater importance as competition for hospital privileges escalates as the result of the increasing physician population accompanied by the closing of numerous hospitals. Therefore, the true impact may not be felt until several years after the National Data Bank is fully operational.

The Secretary of HHS has edicted that this Data Bank begin activity the second half of fiscal 1990 which would be some time between April and September 1990. Unisys has been working diligently since the final rules were published on October 17, 1989 and will try to have everything in place some time in April 1990.

The Law is clear that the "professional society" is included under the definition of a health care entity. The hallmarks of a professional society which will be required to report to the Data Bank are as follows:

- 1) Engages in peer review.
- 2) Has formally adopted written procedures for this peer review.
- 3) Provides for adequate notice and opportunity for hearing in the peer review process.
- 4) Conducts professional review activities for the

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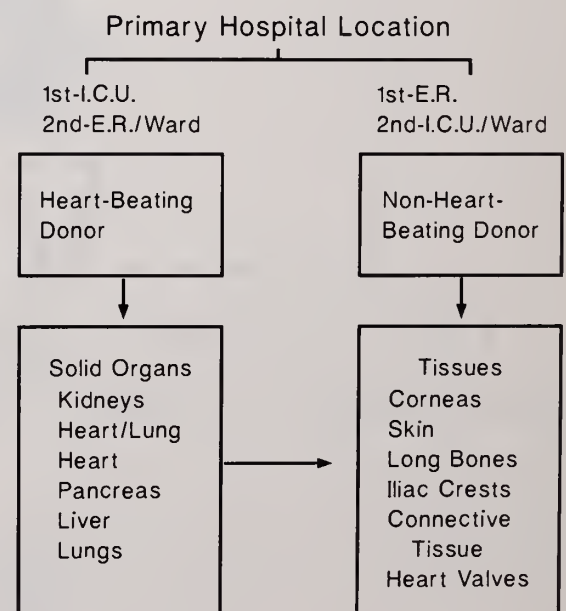
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purpose of furthering the quality of health care.

With these four points there is no question that the American Medical Association and its state affiliates as well as other professional societies meet these above criteria. The professional societies must report adverse determinations resulting from professional review activities on membership, not just loss of membership. The adverse actions regarding membership might include: the reduction, the restriction, the denying, the suspending, and the revoking of membership. It does not include censure or reprimand. Actions such as letters of concern or other informal actions need not be reported.

Dr. John Hansan, Ph.D. was hired by Unisys in February 1989 to be the project director. It is his opinion that the Data Bank is designed to be a "flagging system," one step in the credentialing and privileging process. Dr. Hansan explained that the Data Bank is only a secondary source of data. The primary sources of data reported from the Data Bank are to be found in the files of state licensing boards, hospitals, or medical malpractice payors. Thus, data from the Data Bank does not constitute evidence that an individual is incompetent to provide care; however, when it is revealed that the Data Bank has a report on a practitioner, it is assumed that this fact will be incentive for the hospital or health care entity to look more carefully into a practitioner's background before offering employ-

ment or privileges.

It is estimated, just for planning purposes, that the Data Bank may receive as many as 5,000 adverse actions annually from professional societies. The medical and dental societies must report adverse actions within 15 days of the action being taken. They must report to the State Medical or Dental Board in the state in which the society is located. The State Board has 15 days from the receipt of the professional society's report to transmit this information to the Data Bank. Additionally, for planning purposes the Data Bank officials estimate approximately 10 actions from each of the 7,200 hospital beds annually. Hospitals must report actions that adversely affect a physician's clinical privileges for longer than 30 days. These actions must be based on the practitioner's competence or professional conduct. Hospitals must also report accepting restrictions of clinical privileges while the physician is under investigation.

Probably the largest number of reports to the Data Bank will be those reported by the medical malpractice payors. The payors of medical malpractice actions must report each payment to the Data Bank. The Law is very specific in that it requires the filing of a report of every payment of any amount. The report of the payment must be sent simultaneously to the Data Bank and to the state medical licensing board within 30 days after the payment has been made. Payments made by a hos-

pital do not have to be reported. The Data Bank's primary function is to gather information regarding the individual practitioner.

A hospital is the sole entity that is required by Law to query the Data Bank. As mentioned earlier, hospitals must query the Data Bank every two years regarding physicians who are currently on their staff or those to whom they plan to grant clinical privileges. Any state licensing board must inform the Data Bank within 30 days after they have asked a physician to surrender his license. Medical malpractice insurers may not request information from the Data Bank. Again, physicians may request information about their own file at any time.

The security of the National Data Bank information will be as strict as humanly possible. The Bank will be located in a Defense Department secured facility in Carmarillo, California. There is restricted physical access as well as restricted computer access. The staff of the Data Bank will be subjected to strict security clearances initiated by the United States government. Information from the Federal Data Bank cannot be disclosed in any unlawful manner, subject to a \$10,000 civil penalty.

The practitioner will be notified at any time his file is queried or information is added to his file. The physician's Data Bank record will have an entry for every query that has ever been made regarding his record. He will know who has been looking at his record and how often they have been checking his record.

Dr. Donald Crandall, a general surgeon in Muskegon, Michigan, has been very active in AMA affairs and expressed his views regarding the practitioner's perspective of this National Data Bank:

1) Plaintiff attorneys cannot query the Data Bank, however, there is a possibility that the plaintiff attorney could subpoena the information that the physician obtained when he queried his own file in the Data Bank.

2) At this time the medical malpractice insurance companies cannot query the Data Bank but they could possibly rule that you cannot have insurance unless you provided them the information in your file from the Data Bank.

3) The possible effects on the Impaired Physician's Program is also a concern. The report of the suspension of privileges for an impaired physician is not reportable provided it is not part of an action against the individual. If a practitioner who is impaired "reaches out" for help before he gets into trouble and is out of practice for longer than 30 days this is still not reportable. It will only be reportable if he has continued to work while he is impaired and he has a series of adverse occurrences.

4) At the present time a person can obtain information from the Data Bank provided they send an affidavit stating that they have authority to enter the Data Bank. With the appropriate affidavit the

individual will be given an access number. There is considerable concern as to how this is going to be controlled.

The AMA House of Delegates also has several concerns:

1) They had asked that settlements and judgments less than \$30,000 not be reported. This request was denied. The law states that the Secretary of Health and Education must receive a report at the end of one year on all of the small claims and determine at that time if there is a problem and if continued reporting of these smaller amounts will be necessary.

2) The House of Delegates recommended that all actions other than revocation of licensure should be purged after five years. It was pointed out that in the case of the driver's license, DUI, and speeding actions are removed at the end of a five year period. This request was also denied.

3) The proctoring of a physician's activities is more of an educational and observation action and it was felt that his should not be reported; however, it has been determined that proctoring must be reported.

4) If you receive information that data has been forwarded to the Data Bank and placed in your file and you dispute the information which has been sent to the Data Bank you have 30 days to resolve that problem directly with the hospital that made the report. After the hospital makes an additional report regarding your request, you must then query the Data Bank to see that the "new information" was forwarded to your file and recorded appropriately. If you cannot get the differences resolved you have an opportunity to insert in the Data Bank your views on the dispute. Unfortunately, you will be given 300 characters or less than 25 words to try to place an entry that will protect your professional reputation. There is already a movement to make all PRO sanctions reportable. This was not in the initial wording of the Law and was apparently an oversight by the Congressional Committee. The Inspector General has already stated that this will be rectified when further changes are made in the Law.

In spite of the best efforts, probably there is really little one can do to protect this private and sensitive information over the longhaul. Legal challenges will be forthcoming. The Freedom of Information Act is a very powerful instrument.

I wish to apologize for such a lengthy article this month. I want each physician to truly understand what is happening. I know that some of the issues may not be completely clear at this point but at least you have enough information to be aware of what is happening and to begin to prepare yourself to deal with the National Practitioner Data Bank.

It is unfortunate that the National Practitioner Data Bank will not allow space to include all of the positives in a physician's career. Unfortunately, all of the negatives will be "etched in stone." □

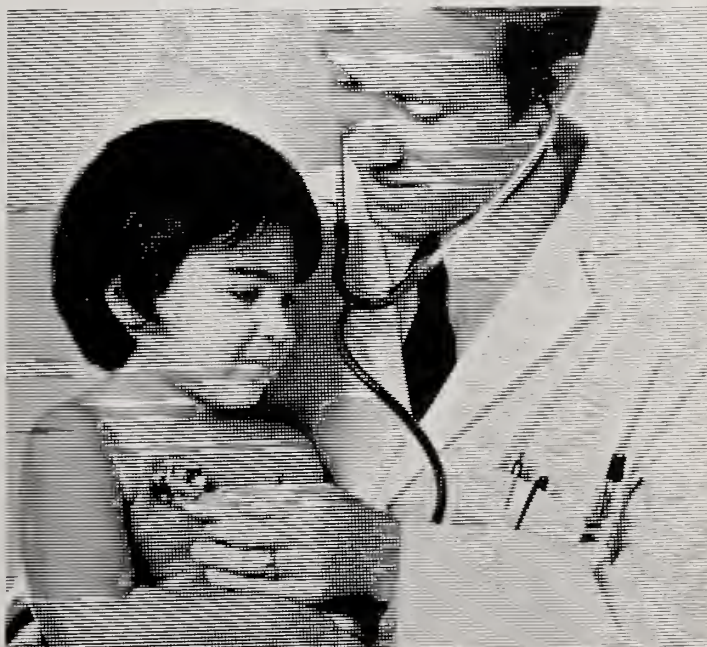
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Dr. Lumpkin: A Pilgrim's Progress

William H. McDonald

On Jan. 1, 1926, the University of Alabama beat Washington 20-19 in the Rose Bowl.

Three days later, Thomas Riley Lumpkin was born in Tuskegee, Alabama.

To try to make something of these events would invite the charge of a classic fallacy in logic, *post hoc ergo propter hoc* (after this, therefore because of this).

Even so, the curriculum vitae of the 1990-91 President of MASA, T. Riley Lumpkin, M.D., at least raises the suspicion of some kind of causal relationship.

Dr. Lumpkin has, after all, been associated with the University of Alabama off and on for the last 46 years, since entering as a freshman in 1944.

After his studies were interrupted by an unexpected 1946 induction in the post-war Army (he had been 4-F during the war, four times rejected because of his eyesight, but was accepted without an eye examination in the rush to replace returning veterans), he returned to Tuscaloosa in 1947 to complete his B.S. requirements; then again in 1953-54 for graduate studies in herpetology before medical school.

He received his M.D. degree from the Medical College of Alabama in 1958. In 1974, he finally answered the call to return as a professor of medicine.

Today Dr. Lumpkin is attending physician/preceptor and Professor of Family Medicine, College of Community Health Sciences, University of Alabama School of Medicine, Tuscaloosa Program, Capstone Medical Center.

He is, in fact, living proof that you can go home again. He's done it often. After finishing his training, he returned to his home county of Macon to practice solo for six years, leaving only when he realized one night that his youngest daughter, then three years old, did not recognize him.

He developed a five man group practice in Enterprise 1965-74, at the end of which he accepted, after a year or so of entreaties, the invitation to return to Tuscaloosa to teach.

With 50% of his current caseload indigent, Dr. Lumpkin is uniquely qualified to address the issues being raised nationally over the perceived necessity for some form of national health insurance to provide for the more than 30 million Americans without any kind of insurance, a number that is said to be growing.

After many years of some indigent care in Tuskegee, Enterprise and Tuscaloosa, Dr. Lumpkin is convinced that totally free care won't work, for several reasons. And he can hardly be called callous: a religious man, he believes medicine is close to a priestly vocation but currently suffering from erosion of that concept.

Before getting to his current views, let's look at this pilgrim's progress to that point.

Back in Tuskegee, Macon County, his father was the bookkeeper for the local Chevrolet dealer. Earlier, during the depression, he had been a hardware dealer

but the depression broke him.

Riley Lumpkin played center on his high school football team, which had as its coach a previous nightclub operator with a bizarre concept of the game. For example, Center Lumpkin would snap the ball, then float to a position roughly comparable to a wide receiver for passes.

The best play the coach had was one he called the peanut play. Center Lumpkin would pretend to snap the ball while surreptitiously depositing it between one of his feet and one of the guard. Amidst cries of fumble, feigned confusion and wild scrambling for the fictitious fumble, he and the guard would contrive to walk calmly away with the hidden ball, sometimes to score.

It worked in Montgomery's Cramton Bowl when Tuskegee High played the capital city's Hurt Military School. The fact that Macon lost in a score Dr. Lumpkin remembers as "about 75 to 6" was of little consequence to the coach — his peanut play had scored. (Florida State Coach Bobby Bowden has tried something similar in recent games, but Dr. Lumpkin believes the inventor was his old coach.)

One thing about those years has probably helped Dr. Lumpkin through his medical practice: for all practical purposes, there were no substitutes. The entire team consisted of 12 players — 11 on the first team and a total of one substitute for all positions, if the sub happened to show up.

"We played both ways the whole game. There was no choice."

The multiple team concept of today — offensive and defensive squads, punt return teams, kickoff teams and the rest of the glitzy specialty formations — seem incredibly luxurious to Dr. Lumpkin in his remembered pain of going both ways for the full four quarters.

That experience has served him well as a family practitioner: calling for help only when absolutely necessary. In fact, it might be a useful addendum to the Family Practice residency pre-requisite: a minimum of one year no-substitution football. It does something for self-reliance.

It was wartime when he finished high school and went off to Tuscaloosa for his first year 1944-45. Four times he was called up for an induction physical. Four times he was turned down and classified 4-F because of his eyes. But at war's end, with millions of veterans clamoring to go home, the Army relaxed its standards. On the fifth trip to Fort McClellan he passed because they didn't check his vision.

Off he went to a freezing Camp Shelby, Mississippi, in January 1946. So confident had he been that he would be rejected again, his friends in Tuscaloosa didn't know where he'd gone.

When the vast World War II demobilization had settled down, the Army told him he could get out, after 11 months and 15 days. But then the draft was rein-

stated and he was told that his best protection from going back was to join the National Guard. He did that.

Then came Korea; the Guard was activated and he found himself in the Dixie Division, 167th Infantry.

"They were taking out a sergeant, a corporal and a private and sending them to Korea. They'd send back dead bodies, and put in a demand for, say, four corporals, five sergeants and so forth. If you volunteered, you would jump up one grade.

"There were only three people in my company who were able to understand the training program. I was one of them, there was a guy from Anniston and a Birmingham policeman. At night we would be taught what we were expected to teach the troops next morning.

"Don't even think about going overseas, I need you here," they were assured by their company captain, Jack McKewen (who'd played football for Alabama back in the late 30s when Bear Bryant was an assistant coach to Frank Thomas).

"Capt. McKewen taught me the manual of arms, military command and so forth one day and the next day I would teach the troops."

Although he had been a male nurse in his first tour with the Army, this time, in addition to judo and close-order drill, he qualified as a moonlighting expert in communications, intelligence and reconnaissance, ranger training, aircraft loading, etc. He was discharged in 1952 as Sergeant First Class.

In his first two interrupted episodes at the University he had been classified pre-med, on the strength of which the Army had sent him to Fort Benjamin Harrison, near Indianapolis, to make an Air Corps male nurse and surgical technician out of him.

He had first attempted to get into medical school in 1948. But all the returning vets were getting in ahead of him with better grades. Keeping the gates of medical school in those days was Virginia Baxley, registrar for Dean Graves, as formidable as Cerberus guarding the Gates of Hell.

"Her opinion was most important. If she thought you were qualified, you were almost assured of admission."

After his Korean war service, he did not return to beard that lioness again, but took a job as close to medicine as he could find — selling surgical equipment out of Madison, Wisconsin. Because he had been in the medics, he would often be invited in the operating room.

Once he called on a surgeon who asked him to help him with a gall bladder. Then he asked the knowledgeable salesman why he didn't go to medical school. The explanation that he had been rebuffed seemed inadequate to the surgeon: "You ought to go," he said emphatically. Dr. Lumpkin recalls:

"I got to thinking about it again and decided to go back to college." After all, there were limitations in his

four-state sales territory.

Back in Tuscaloosa to work on his M.S., having already earned his B.S., he concluded that the first priority was good grades, the better to open the door. Out of the blue his graduate mentor said he wanted somebody "to do snakes." Okay, Riley Lumpkin said, "I like snakes. I'll do it." Thus was born the herpetologist who still lectures and writes about snakes.

It was in 1953, in his third incarnation on the Tuscaloosa campus, that Dr. Lumpkin met his future wife, Jean, a student eight years his junior. They immediately established a common bond: "She was one of four girls; I was one of four boys."

Not the world's most amazing coincidence perhaps, but sufficient nutrient for their romance to grow on.

His medical training completed, he went back to Tuskegee, Macon County, to practice solo, the only doctor in town. He survived six years, killing himself doing just about everything, seeing 120 patients a day and making 5 to 10 house calls a day. For his endless labor he considered himself lucky if he collected 60% of his charges.

Shortly thereafter they moved to Enterprise where a partnership suddenly reduced his caseload from 120 patients a day to 30; his house calls to about one a month.

This was pure heaven. The Lumpkins lived on 20-acres of woods and field; the Doctor had time to enjoy it and his family. He learned the simple pleasures of being home at night and some weekends.

It was only after nine years that Dr. Lumpkin began to consider seriously an academic offer he had been refusing for a couple of years. Although Enterprise was Eden compared to Tuskegee, every Eden has a snake or two, and the fourth return to Tuscaloosa became more attractive.

In 1974, he took the plunge. He has never had reason to regret the 16 years of academic medicine. He is permitted to have two half-days a week for private practice, which now comprises about a fourth of his total caseload. He is, for example, caring for a lady law student and her child — all in all, a gratifying mix.

Dr. Lumpkin has an abiding religious faith but he is not smug about it; quite the contrary. A resident in his Ethics class, where Dr. Lumpkin tries to keep discussion ecumenical, demanded to know where the professor was coming from in one of his views. Was Dr. Lumpkin a Christian?

"I'm trying to be," he said.

The challenger thought the answer evasive. "Either you are or you are not," he said, demanding a yes or no answer.

"I repeat: I'm trying to be. It's a constant battle. Whether I have succeeded or not is not for me to judge."

But, accepting Dr. Lumpkin at his word, his effort to become a fully practicing Christian is impressive. He

has served the Methodist Church in a variety of capacities in Tuskegee, Enterprise and Tuscaloosa; taught adult Bible classes; served as chairman of the Methodist Men's Club; on the board of stewards and as Chairman, etc.

But you find in his CV an expanse of activities that, while not strictly religious in nature, do underscore his continuing effort to be a Christian in all that might encompass in his personal definition.

He has toiled for many years in the vineyards of the Boy Scouts, Salvation Army, Rotary Foundation, Rescue Squad — the list goes on, attesting to his many good works and humanitarian contributions. His leadership in the Medical Explorer Scouts of Tuscaloosa, for example, resulted in a number of high school students going on to medical school and nursing school. A former Explorer is now a charge nurse at DCH Medical Center. Others have been in his residency program.

In short, his answer to the inquiring member of his ethics class was accurate, if somewhat self-effacing — he has tried and is trying. If a recovering alcoholic can be said to have made it after 50 years in the straight lane, an outsider might conclude that Dr. Lumpkin, the evolving Christian, has probably passed muster. But don't tell him: medicine and his fellow man benefit too much from his uncertainty.

In a recent interview Dr. Lumpkin was asked whether the once interlocking of religion and medicine, now largely passe', was a good thing. He replied:

"In my ethics presentations, I try to get people to look behind any human relationship, not just the doctor-patient relationship. You accept people for what they are. You don't browbeat them or lowrate them because they're not as educated as you are, or a different socio-economic group.

"I'm afraid we are all guilty of doing this. In many ways, we have just as much of a caste system as India. (Dr. Lumpkin was team physician for the Dr. Akbar Haqq Crusade to India in 1974.)

"We must get back to the point where we acknowledge medicine as an extremely important gift and that this gift carries enormous responsibility.

"Medicine is almost a priesthood, and that is the problem; we accept the god-like image but we don't want to do the necessities to maintain that image. For example, there have always been a certain percentage of physicians who were greedy. You accepted that. But now there are more and more. There are too many physicians who can rationalize gouging the government, because, 'that's free and I don't have to worry about that. I don't have any moral obligation not to gouge the government.' But we are the government.

"But the whole country seems to be living in a period of anything goes. The average American nowadays doesn't care or seem to care about anybody but himself. You see it in big things and small things. You see it in

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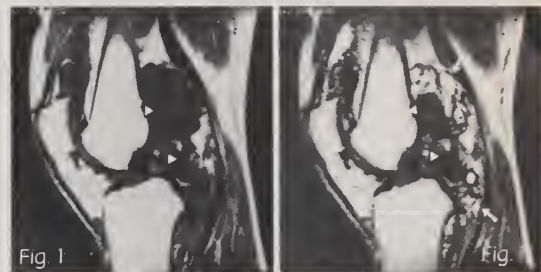


Fig 1

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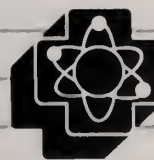
Fig 1: Sagittal T1 (TR/TE 817/20) and T2 (TR/TE 2000/80) weighted images of the left knee reveal multiple, nodular, soft tissue masses (arrowheads) within the articular space and suprapatellar recess which display low signal intensity on both sequences due to the paramagnetic effect of hemosiderin. There is a surrounding joint effusion and juxta-articular cysts (arrows) present as well.

Fig 2: Lateral radiograph of the left knee reveals soft tissue fullness in the popliteal fossa as well as in the suprapatellar recess. No significant bony erosions identified.



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traffic and everyday life."

Dr. Lumpkin recalled a recent incident that may be revealing. His son called at his office to tell him he was getting a job. That's fine, the father said, but he wanted to know if his son had told his new employer that he also had another job, teaching tennis. "It is very important that everyone knows what you are doing," he admonished his son.

Residents who overheard the conversation were laughing. "That's so old-fashioned," they twitted. Dr. Lumpkin:

"But it's not old fashioned, or if it is, we are in deep trouble. Total honesty with yourself and others is really what ethics is all about.

"I see a whole new attitude in young physicians, and I can't say that it's all bad. I ignored my family; my patients came first. Today's resident is paying more attention to his family. When he must choose between his patient and his family, he chooses his family.

"In my own experience, my family was almost totally pushed into the background. When I was absent from home or from church, it was understood. And that's what one of my own daughters said, when she decided not to try for medical school: 'I don't want to work like you did. I want to be at home with my family.' She remembers what it was like."

Question: "And your children, whom you probably gave far more than you received as a child, wanted the life you provided for them but not the life you lived?"

"Exactly right. Somewhere between what I did and what this generation wants might be a happy medium. I don't know. I do believe that childhood now is emptier — although it may seem fuller to today's children — than it was. We made our own toys and games. We didn't have TV to spare us the mental work of imagination, we were inspired by books and an occasional movie.

"But however Americans got where they are now, the tendency today is to cut corners and take the easy way. Is it any wonder that we are no longer the industrial power we were, and that economic leadership is slipping from us? We didn't get to be the world leader and world power we were by cutting corners.

"There is a related corruption in religion. Many people think that once you are saved, that's it. Anything you do is okay. It is particularly disturbing to see this in the south, one of the last bastions of this

kind of value now being eroded. That was why the South has been so appealing to outsiders.

"I see depersonalization going on everywhere. Physicians are trying to become too impersonal. Sick people need a personal one-on-one relationship with their doctor.

"The specialties were spun off from the basic physician, and we need the specialties, but we also need the basic doctor."

But Dr. Lumpkin, though he cares about the medically indigent and worries about their fate in a world becoming increasingly self-centered, is not a starry-eyed sentimentalist. He believes that any national health plan, possibly emulating Canada's, is doomed if it is totally free at the point of service. Everyone, he believes, must take some personal interest as well as

financial responsibility in his own health. Otherwise direct treatment is less effective and economic disaster awaits down the road. Totally free health care is, by definition, inferior and belittling to the patient.

As President of MASA, he believes the *sine qua non* for any medical reforms in this state — for example, Medicaid expansion — is the unity of purpose between the specialties instituted as an Association objective by his predecessor in the office, Burt Taylor, M.D.

"Burt has a great idea and I want to continue that. We are not all going to walk in exactly the same formation, of course. Then we should all walk in the

same direction, that of 'the patient comes first.' But at least we can be made to understand that if we are divided we are going to continue to be divided. Americans generally have become so individualized we don't care about other people and this same process has infected medicine.

"Before anything else can be accomplished, physicians must be rededicated to their being brothers in service. Physicians, like others in the population, have forgotten how to care for each other. We must relearn that. If we don't have the brotherhood and cohesion, how will we ever achieve something like Medicaid reform?"

"The profession is not a profession any more in that sense. The Legislature can only be made to understand that we are the bulwark of medical care if we present a united front.

"Fragmented, as now, we are not sending that message. This needs to be changed for the good of our patients and, in the long run, the good of physicians." □

"Before anything else can be accomplished, physicians must be rededicated to their being brothers in service. Physicians, like others in the population, have forgotten how to care for each other. We must relearn that. If we don't have the brotherhood and cohesion, how will we ever achieve something like Medicaid reform?"

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Frank Cochran

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The Costs of Smoking

Clifford J. Hataway, M.D., M.P.H., Earl Fox, M.D., Jim McVay, M.P.A.

Alabama's health care system is experiencing significant difficulty with health problems relative to health care resources. Many problems have been identified and major efforts are underway to develop solutions. The problems include uncompensated care, closing of rural hospitals, uninsured and under insured persons, low Medicaid funding, and loss of obstetrical services. There is an increasingly well documented data base demonstrating chronic diseases are the predominant causes of morbidity and mortality with associated health costs. It is well documented that certain lifestyle patterns, particularly the use of tobacco products, play a critical role in the development or aggravation of many of these diseases. Although extremely hazardous, tobacco products are legally obtainable. They are currently taxed as supplemental revenue resources with no consideration of health policy relating the tax to tobacco-induced health problems and costs. This article will address the tobacco tax in Alabama, its historical trends, and implications of that tax structure.

The tax was initiated in 1927. Revenues from it are allocated among several areas within state government including public health, mental health, human resources and education. A key public concern is whether or not those revenues are adequate to provide enough public benefits versus the costly public health problems which can clearly be tied to tobacco use. The question is whether or not the tax is at least at a minimally acceptable level to counterbalance health care expenditures.

Tobacco taxes reflect combined Federal and state levies. Federal tobacco excise taxes have been static over the last thirty-six years without one increase. The last increase was in 1987, increasing the tax from \$.08 to \$.16 per pack. There is no projected increase in the near future due to extensive lobbying by the tobacco industry. Minnesota currently has the highest cigarette tax at \$.38 per pack with portions of the tax earmarked to health and cancer-related pro-

grams. California's tax was increased in 1988 to \$.35 per pack and is projected to raise over \$ 650,000,000.00 annually. This revenue will innovatively be spent on health promotion, youth education, and uncompensated hospital care. Hawaii's tax is 40% of the wholesale price and is \$.29 per pack.

In contrast, the current Alabama tax per pack is 16.5 cents which equates to a millage rate of 8.25 mils/cigarette. This is the 16th lowest tax in the country. Tobacco revenues provided approximately 72.5 million dollars for fiscal year 1987-88, ranking eighth among all State tax dollar sources. The millage rate has increased slowly and inconsistently since its initiation in 1927 with the last increase in 1984. State revenues from tobacco have increased minimally over the last three years, in part because the millage rate has stayed constant and the volume of products sold has not increased.

An examination of the tax can provide a perspective to determine if the current tax level is at least adequate. Table 1 shows the effect on the cost of an imaginary item in 1960, and at three subsequent points in time, as affected by the consumer price index (CPI). Table 2 shows the actual millage rates in Alabama over the same time and that rate would be today if tied to the CPI. Table 3 contrasts per capita sales of cigarettes, the change in average retail price, the percent of state and Federal excise taxes of retail price, and the associated percentage changes in each category since 1960.

With the millage system, it is obvious that change per unit can increase but the tax revenue yield will still be the same. If the price of cigarette increases significantly, millage per cigarette and tax return per pack will not increase. Profit margin will, however. The change in the sales prices of Alabama tobacco products undoubtedly reflects a combination of profit and inflationary adjustment. The data shows that the effect of past inflation has resulted in proportionately less revenue for the state since 1960. It is reasonable

TABLE 1
Projected Change in Cost of an Item Relative
To Change in the CPI, 1960-1988

Year	Unit Value Or Cost	Aggregate CPI % Change
1960	1.00	—
1970	1.30	130%
1980	2.75	275%
1988	3.93	393%

TABLE 2
Alabama Tobacco Excise Charges Per Pack
and CPI Adjusted Tax, 1960-1987

Year	Tax Per Pack	Percent Change	Projected Tax Level
1960	1.00	—	—
1970	1.30	200%	\$.08
1980	2.75	0%	\$.165
1988	3.93	260%	\$.236

TABLE 3
Cigarette Per Capita Sales Contrasted to Retail Price/Packs Percent
Excise Taxes of Retail and Percentage Aggregate Changes, 1960-1987

Year	Cig. Per Capita Sales	% Change Sales	Avg. Retail Price Pack	% Change Retail Price	St./Fed. Tax % of Retail	% Chng. Com- bined Tax
1960	87.2	—	28.4	—	49.3%	—
1970	89.8	103%	38.6	139.6%	50.5%	102%
1980	123.2	141%	60.6	213.4%	33.0%	-30%
1987	114.0	131%	1.10	338.7%	29.6%	-40%

to suppose that this is a major loss of revenue from this source as the millage rate was not adjusted to modestly keep pace with inflation.

The politics of suggesting an increased tobacco tax unfortunately is adamant opposition to additional taxes on "poor" tobacco users. Under the current system, the state gains revenue when more tobacco is sold, a paradox relative to the hazards of the product. It is even more paradoxical that no legislators comment about the amount of health expenditures related to tobacco use and supported by State tax laws while many fiercely protest increasing tobacco taxes.

It can be argued that massive increases in the tax would be detrimental by causing less tobacco use and less revenue as the tax is increased. The greater poli-

cy concern should be the problems with low funded Medicaid programs and rural hospitals saturation with unfunded indigent care. It seems reasonable that a solution would be to increase the tobacco tax in a graduated fashion and provide more support from that increase for those problem areas.

Additionally, it has been suggested that a modest number of teenagers would be deterred from early tobacco usage by increased taxation. The effect of this would be a potentially healthier workforce, as excessive tobacco related illnesses are avoided by those decisions. This would seem more appropriate for state policy planners and legislators to consider. The legislature could better serve the public with more appro-

(Continued on page 31)

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Coronary Angioplasty in Acute MI

*Silvio E. Papapietro, M.D. Joaquin G. Arciniegas, M.D., Michael T. Simpson, M.D.,
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William A.H. MacLean, M.D., William J. Rogers, M.D.*

Despite the important findings and implications of the TIMI 11 Trial in the treatment of patients with acute myocardial infarction, several issues remain controversial and unresolved, including the following:

¹For some patients excluded from TIMI 11, like those over 75 years of age in whom the bleeding risks with thrombolytic therapy may be increased, or in those with absolute contraindications for thrombolysis, the optimal therapeutic strategy has not been identified. It is likely that in these patients immediate PTCA without thrombolysis ("direct PTCA") may be safer than thrombolytic therapy, but a randomized trial would be required to evaluate the benefits and risks of thrombolytic therapy versus direct PTCA.

²Since the reperfusion rate of the most effective thrombolytic agents approaches only 75%, how to treat the remaining 25% of patients in whom thrombolysis fails to recanalize the infarct artery is also unclear. This is particularly important in patients with large infarction and hemodynamic instability. It has been proposed that when evaluation 30 to 60 minutes after initiation of thrombolytic therapy suggests the infarct artery has not been recanalized, cardiac catheterization and PTCA ("salvage PTCA") should be performed if the infarct artery remains occluded⁶. However, despite a high primary success rate, salvage PTCA is associated with high hospital mortality, high reocclusion rate, and no apparent preservation of left ventricular function⁶. Thus, how to proceed with the patient in whom we suspect thrombolytic therapy has failed remains an important dilemma facing the invasive cardiologist. Should we at this point in time give up on additional efforts to recanalize the infarct artery or should we perform cardiac catheterization and salvage PTCA, knowing the risks are increased, considerable time has elapsed while we waited for thrombolysis to reperfuse the artery, and the benefits of PTCA under these circumstances remain unproven. To make this decision even more difficult, recent studies have demonstrated that recanalization of the infarct artery even late after onset of symptoms can improve longterm survival by mechanisms different than limitation of infarct size⁷. The beneficial effects of late recanalization may result from prevention of infarct expansion, left ventricular dilation and aneurysm formation, and by promoting electrical stability of the infarcted myocardium^{7,8}. These unanswered questions offer exciting and challenging prospects for research in alternative therapies after failed thrombolysis.

³It has been suggested by some investigators that the administration of a relatively "nonfibrin specific"

thrombolytic agent, like urokinase or streptokinase, may improve the effectiveness of salvage PTCA after failed thrombolysis with a relatively "fibrin specific" agent, like r-TPA⁹. This has been attributed to the greater hypocoagulable or "fibrinolytic state" associated with the use of the former agents, that may reduce the risk of reocclusion after PTCA. However, these preliminary findings have not been confirmed, and a prospective randomized trial would be needed to evaluate the influence of different thrombolytic agents or combinations, in the success rate of PTCA.

⁴The treatment of cardiogenic shock complicating acute myocardial infarction remains a major challenge, and was not directly addressed by TIMI 11. Although there has been no randomized study comparing thrombolytic therapy and direct PTCA in post infarct cardiogenic shock, therapy with intravenous streptokinase did not reduce mortality in patients with cardiogenic shock in the Italian GISSI Trial¹⁰. Some experts believe direct PTCA is the preferred treatment for this condition, and this impression derives from studies comparing outcome of patients in cardiogenic shock treated with direct PTCA with historical controls treated conventionally. These observational studies have strongly suggested a significant reduction in the mortality of patients with cardiogenic shock with successful PTCA of the infarct artery¹¹.

⁵Although TIMI IIA found that PTCA performed during thrombolytic therapy with r-TPA was associated with greater bleeding complications and lower success rate than PTCA performed 18 to 48 hours later, caution should be exerted in assuming that these suboptimal results were entirely related to PTCA. It can be anticipated that a procedure that causes splitting of the intima and dissection of the media may result in more extensive bleeding and hemorrhage of the arterial wall, and a greater likelihood of abrupt closure, when performed under the effects of r-TPA than in the absence of a thrombolytic agent. Thus, it is inappropriate to evaluate the effectiveness and safety of PTCA in the treatment of acute myocardial infarction when the procedure is performed during administration of a thrombolytic agent, since thrombolysis may predispose to more frequent and severe complications. Many experienced interventional cardiologists¹² believe direct PTCA (without thrombolytic therapy) is as effective or superior than thrombolysis to recanalize the infarct artery in acute myocardial infarction. However, even if direct PTCA is highly effective in this setting, it is not realistic therapy for the majority of patients evolving a myocar-

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dial infarction, particularly in geographic areas where cardiac catheterization facilities are not readily available.

⁶Caution should also be exerted in extrapolating the results of TIMI 11 to patients treated with thrombolytic agents other than r-TPA. Even though streptokinase, urokinase or anisoylated plasminogen activator complex (APSAC) may be as effective as r-TPA in acute myocardial infarction, their different effects including less fibrin specificity and a more prominent hypocoagulable state may influence PTCA differently than r-TPA. In many countries r-TPA is not available because of high cost, and without studies evaluating the safety and effectiveness of PTCA performed in the presence of other thrombolytic agents, the TIMI 11 results should be interpreted cautiously by physicians not using r-TPA.

Based on what we have learned from TIMI 11 and some of the considerations previously discussed, we present our current approach to the management of acute myocardial infarction. Patients with acute transmural infarction presenting to our institution within four hours from onset of pain, who are less than 75 years of age, have no contraindications for thrombolysis and are hemodynamically stable, receive r-TPA (100mg over 3 or 6 hours), and intravenous heparin (5000 units as a bolus followed by an infusion to maintain the partial thromboplastin time 2 to 2-1/2 times above control). If they have no contraindications for beta blockade, they also receive metoprolol intravenously (15mg over 6 minutes) and orally (50mg twice daily the first day and 100mg twice daily thereafter). Aspirin 75mg daily is added on the second day. Intravenous heparin is discontinued on the fifth hospital day, at which time the dose of aspirin is increased to 325mg daily. Those patients in whom the clinical course suggests successful reperfusion and who have no recurrence of myocardial ischemia undergo submaximal exercise testing prior to hospital discharge. If there is no evidence of myocardial ischemia on exercise testing they are discharged home on aspirin, beta adrenergic blockers and nitrates, and scheduled to return for a maximal exercise test at six weeks. Those patients in whom the clinical course suggests failed thrombolysis (persistent chest pain, ST segment elevation, or clinical deterioration), or who develop recurrent ischemia at rest or at predischARGE exercise testing undergo cardiac catheterization and PTCA of the infarct artery if a suitable lesion is identified. In patients with acute pulmonary edema or cardiogenic shock, we currently prefer not to use thrombolytic agents, and proceed with cardiac catheterization and direct PTCA.

In patients with contraindication for thrombolytic therapy in whom we suspect the infarct artery is large, we also perform cardiac catheterization and direct PTCA. If electrocardiographically we suspect the infarction is small and the patient is elderly and hemodynamically stable, we consider conventional therapy.

Patients presenting within 4 to 24 hours from onset of chest pain are also considered for emergent cardiac catheterization and PTCA, particularly if they have persistent pain and ST segment elevation. This aggressive approach to patients presenting late after onset of pain derives from the previously discussed studies indicating that even late reperfusion may reduce mortality in myocardial infarction.

The recent introduction of portable cardiopulmonary support systems has enabled the performance of PTCA in extremely ill and even moribund patients, including those with sustained ventricular dysrhythmias or during cardiac arrest. New technology for intracoronary interventions, including different approaches to laser angioplasty, vascular stents, and atherectomy catheters will expand the uses of PTCA, reducing complications and improving longterm results. The TIMI 11 Trial has generated important information concerning the role of PTCA in acute myocardial infarction. The findings of this multicenter Trial provide a scientific basis for the treatment of myocardial infarction and should minimize interventions based on observational studies, "personal experience" and preferences, and anecdotal reports. The exploding interest in research and technology to treat atherosclerosis and thrombosis will lead to the development of more effective and safer thrombolytic strategies, new devices for intracoronary interventions and cardiopulmonary support. Many of the present uncertainties in the therapy of myocardial infarction will soon be resolved. □

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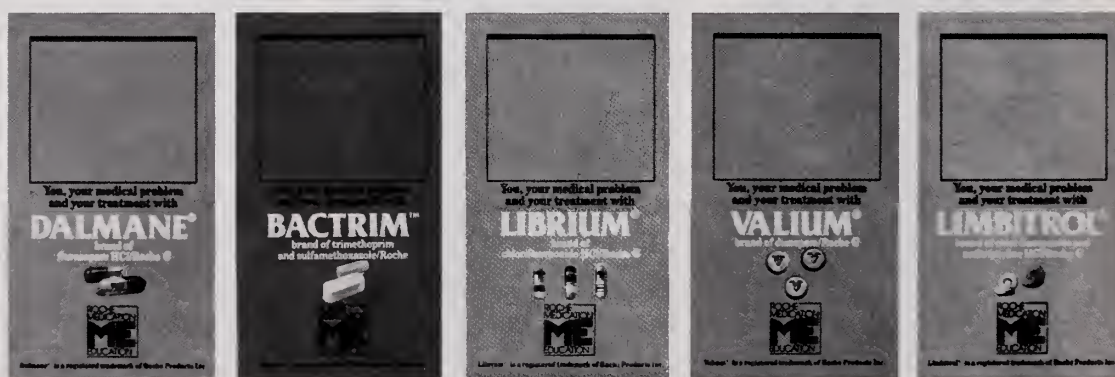


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Dirty Old Doctors Need Loving, Too!*

Do you feel put upon, unhappy, disagreeable, unloved? Does your spouse not seem to have time for you—to listen to you, to hear your concerns about your practice, to know how upset you are with government interference with not only day-to-day minute decisions, but with major decisions about the treatment of your patients, the time you can schedule surgery, the length of stay in hospitals for even desperately sick patients? Perhaps you do not have someone waiting for you when you come home, tired from endless decisions and worrisome, troubled patients. Perhaps you do not have someone to be with you at that all important meeting, or that luncheon that you must attend for business purposes. It's frustrating, isn't it? Yes, dirty old doctors AND spouses need loving, too!

It has been said that a physician's success is often measured by the size of the practice, respect of colleagues, and esteem of patients. That is good, because if success were measured by the health of marriage and family life, many physicians would be considered dismal failures. Many experts say that the partners in medical marriages have a higher than average rate of unsatisfactory relationships.

We all know that medical marriages ARE different. Physicians are loyal to their profession, and it is their top priority, for which they take on excessive and unrealistic workloads and expect their spouses to understand. Often, the physician-partners are immersed in medicine while their spouses are making any adjustment that they can—feeling good because there are so many things to do, or resigned that the choice has been made and must be lived with.

In offices, physicians are the authority and the authoritarian figures in their practices. Too often, the mantle is not shed at home. They may treat their spouses and children as patients, and issue "orders", that are expected to be followed without question.

Physicians must practice emotional control at the office and hospital, but this can turn into a lack of emotion at home. Spouses may be amazed that the physician-partners that they look to for strength need enormous amounts of emotional support, but are unable to provide an equal amount of support in return.

Spouses often resent the time the physicians spend away from home and the family, and may feel short-changed and angry. They wish they could be more selfless, but they, too, have needs that must be met.

The challenge is for the medical family to keep the lines of communication open, so that conflicts are recognized and dealt with. The key to a successful medical marriage is for the partners to deal with the problems before they reach crisis proportions. Needed are love, quality leisure, and lots of laughter to bond and add joy to the marriage.

For many, the answer lies in compromise, in which each partner knows just when and how much to bend. For physicians, that means learning to shift gears when they are at home. For spouses, it means realizing that they can't take everything personally.

Both partners need to remember the essential qualities that brought them together. If you loved each other enough to get married, you should be willing to work together to maintain the marriage and increase your feelings for each other.

Now, I challenge you, doctor or spouse (whoever has managed to read this far)! Why don't you plan a special dinner for your spouse this week? How about biting your tongue rather than retorting with a short, clever, unloving reply? What about an interesting week-end away where there are no office-patient emergencies?

My physician-spouse suggested this title, and said

*Any Medical school graduate

that every Alabama physician would read an article with such an interesting title. Was he right? Are you continuing to read? If so, I must tell you that this year as President of the Auxiliary to the Medical Association of the State of Alabama has been interesting and I have loved every minute of it, but my spouse falls into the category of neglected spouse, just for this year. He has been most understanding, and my year is about over, and I once again will become the spouse he has known for all these years. Your career, doctor, lasts a lifetime, so there's no make-up time. Let's communicate, discover what problems exist, and all become more loving to our spouses day by day! As ever, "Knowledge First—Then Action"! □

Cost of Smoking

(Continued on page 21)

priate long term thinking about tobacco taxes and health care expenditures rather than repetitive non-productive debate.

In California, part of the rationale for the tobacco excise increase was the documentation that only 22% of all Californians smoked but 77% of all hospitalizations were smoking related. Some researchers argue in spite of this documentation that smokers currently pay in the aggregate for their smoking-related health problems. At any rate arguments against raising the "excessive" tobacco taxes in Alabama can be rejected because the tax is not excessive. The amount of revenue loss since the 1960's could have eased some of the current revenue shortfalls experienced in the state. Health services might particularly benefit because the appalling impact of tobacco usage on nonusers and users health is, as documented in California, a major contributor to health care costs while health care dollar resources are shrinking. The deceptive arguments against increased tobacco tax revenues need to be openly discussed. Either appropriate tax increases for this hazardous substance or an inflation-based adjustment, seems in order. □

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in *Rauwolfia Serpentina* (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

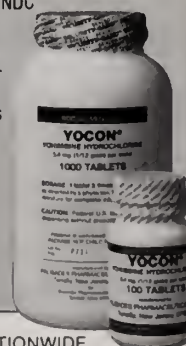
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How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., *New England Journal of Medicine*: 1221. November 12, 1981.
2. Goodman, Gilman — *The Pharmacological basis of Therapeutics* 6th ed., p. 176-188. McMillan December Rev. 1/85.
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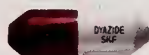
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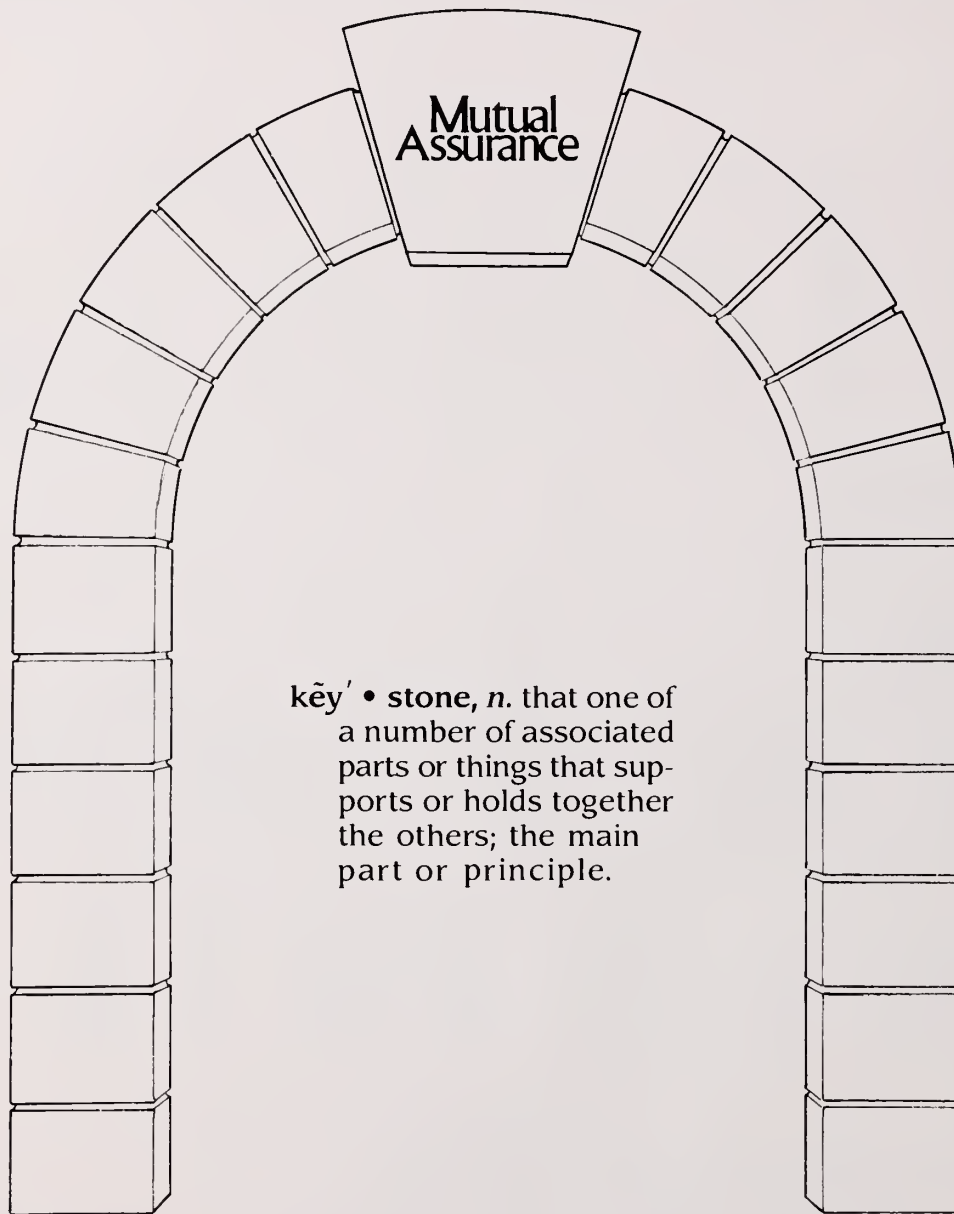
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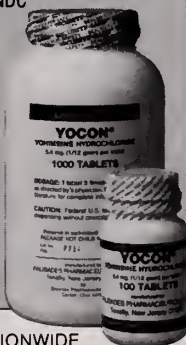
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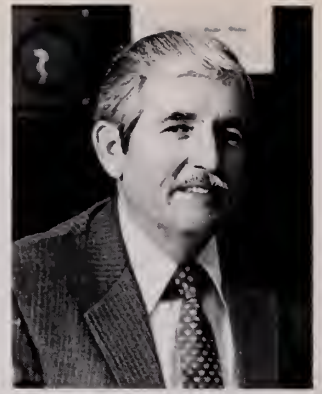
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These lines from the works of John Donne, the 17th Century English theologian, preacher and metaphysical poet, have a special poignancy as the world approaches the second millennium. Of a sudden, the global village has emerged from the fantasies of visionaries to something approaching reality; the global market already is a reality, at times a harsh one.

The fortunes of the United States are tied as never before to what happens to the rest of the planet. Even during World War II Americans could still pretend to be an island, removed from the dismal affairs of the rest of the world except in occasional wars, from which we could quickly retire and revert to our traditional isolationism.

That day is distant now. We are a piece of the continent, a part of the main, and if the bell tolls for, say, Lithuanians, it tolls for us too, in ways we cannot fully comprehend. Millions of Americans who never gave a thought to the Baltic states are now watching anxiously their struggle to break the bonds with Moscow, which were imposed by the shameless Hitler-Stalin pact of 1939.

Americans, who would have cheered their revolt a few years ago, suddenly regard the aspirations of these subject peoples with some alarm. We fear they will upset the delicate balancing act of a Soviet leader whose success or failure, we have all suddenly become aware, profoundly effects our own future, even our own

pocketbooks.

Consider the radical shifts that the changing nature of the world has already thrust upon our thinking: a Soviet leader in a white hat? Preposterous, you would have said just a few years ago. The United States, champion of the enslaved, suddenly concerned that a captive nation may act impetuously in throwing off its chains? No way, we would have said as recently as 1985.

The point being that while America has been deeply involved in the affairs of the world more or less constantly since Pearl Harbor, only recently have we realized the finite nature of our military and economic power. Only recently have we come to appreciate how impotent we have become to shape major events in either Europe or Asia. If we do not fully understand how the fate of the Baltic states — or of Poland or of Hungary — will effect our own destiny, we are nonetheless convinced that it will, somehow. And we are right.

Since the upheavals and turnabouts in the past year have profoundly altered America's world, it follows that they have also altered medical practice. If the effects are not dramatically evident now, they will be. Like business and industry, medicine must be fitted into the changing world posture of the United States to meet the new imperatives.

For example, the demands of the existing and emerging world markets are now so pressing that this country faces the very real threat of economic subordination by the unified European market on one side of the globe and by the Pacific rim nations on the other.

Until very recently the focus of the world economy was on the Atlantic nations. Now most economists view the shift to the Pacific rim, long predicted, as fast approaching reality.

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nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication. Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions. Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage. Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP

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Additional information available to the profession on request.



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Axid® (nizatidine, Lilly)

Bonn and New York. The capitals of the new order are now being seen as Sidney, Tokyo and Los Angeles.

This shift of economic centers, you will notice, also shifts the political center of the United States from the East Coast to the West Coast, another major change in our national character and how we see ourselves.

To maintain superpower status in this great flux, America must not only remain militarily powerful, but must sacrifice to restore our economic power, now sadly flagging because of multi-trillion-dollar debt and continuing deficit.

The all too easy answer is that we must have a massive tax increase along with all the draconian measures necessary to get our economic house in order. But such reforms, no matter how traumatic, won't do it all, not by a long chalk.

America must also produce and compete as never before to remain viable in world markets that figure to become more and more competitive. We need a rousing revival of the old can-do spirit of our capitalist past, more efficient production, shorter lag times between R&D and the markets, and more planning for the long haul rather than the quarterly report.

I have been among those who have said American industry is flawed by its obsession with short-term profits to the exclusion of investing in R&D and long-range planning. More than a few major industrialists have taken the cry-baby attitude that they can't compete in world markets because of their health care costs.

One of the nation's most astute industrialists, in domestic as well as world competition, is Richard J. Mahoney, chairman and CEO of the Monsanto Company. In a guest essay in *Scientific American* (May 1990, pg. 136) he puts the U.S. plight in a somewhat different perspective.

First off, Mr. Mahoney doesn't even mention health care costs as a factor in world market competition. He begins by showing that but for America's six high-technology industries, our trade deficit would be much worse than it is. These industries — computers, aerospace, agricultural commodities, chemicals, pharmaceuticals and scientific equipment — together generated a net surplus of almost \$60 billion in 1989, an increase of 14% over the previous year.

Without these industries, the U.S. merchandise trade deficit of \$109 billion last year would have been 54% worse.

"Yet," he writes, "global competitiveness of these trade-positive industries is hampered by barriers erected right here in the U.S. My own experience at Monsanto, a company that cuts across several of these industries, has made that painfully clear. There are at least four significant obstacles: the liability crisis in our courts; a regulatory system that slows commercialization of technology; the high cost of capital in the country; and high-technology piracy."

Notice that he places the liability crisis first. He does so advisedly, as he explains:

"In recent years the number of successful multi-million-dollar product liability suits has grown significantly. They have become an unpredictable wild card that dampens innovation. My own company, for example, invented and developed a substitute for asbestos. We abandoned it just before commercialization because we were convinced that a whole generation of lawyers trained in asbestos litigation would see our product as their next opportunity.

"Our story is not unusual but typical. A ... survey of chief executive officers by the Conference Board showed that uncertainty about potential liability has led almost 40% of them to withhold new products, including beneficial drugs and life-saving technology. For the same reason, nearly 50% of them had discontinued existing product lines.

"Make no mistake. I do not argue that companies should not be responsible for the consequences of injuries caused by negligence or manufacturing defects, including medical expenses and lost income. But many recent product liability suits have resulted in astronomical judgments that bear no connection to the extent of harm or to the firm's responsibility. These judgments make liability insurance extremely costly or unavailable, interfere with strategic planning and curb R&D spending and innovation. In the end, society suffers. Other countries are not burdened by comparable liability baggage in their home market, which is where you build strength for competing in the international arena...."

AMA Acting Executive Vice President James Todd, M.D., has said much the same thing in addressing this country's problems of the cost of health care: unless the liability overhead is relieved, most cost constraints will be relatively trivial.

Thus physicians' are hit from all sides by the liability crisis. If America's world trade posture is severely weakened by the threat of massive losses in new or existing products, domestic spending must be severely cut to compensate for trade shortfalls. And the prime target of cuts in domestic spending of late has been in health care. Even the vaunted arrival of practice guidelines or parameters is, at bottom, no more than additional price controls, many economists have noted of late.

Of course U.S. medicine is effected by many other factors involved in this country's eroding position in world markets. But my point is this: as the finest health care system in the world moves apprehensively toward the second millennium, it will be as a bobbing cork on the wild waves of change, driven by cyclonic winds from every quarter. Doctors, whether they realize it or not, are tightly bound to what happens in the world and what happens to America's competitive position in that world.

If the bell tolls for the U.S., it tolls for thee.□



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Burt Taylor, M.D.
President, MASA

Farewell Address

Following is the presidential farewell address of Burt Taylor, M.D., to the College of Counsellors and House of delegates at the annual session in Orange Beach April 7.

Certainly, this past decade has been an extremely difficult time for Alabama's physicians. We have surrendered many of our practice customs and too much of our independence. Our profession has bent significantly but has not broken. We have continued to take care of our patients and somehow have endured the changing environment in which we must now practice.

Let me read a few lines from Dr. R.S. Currey's Presidential Address to the Mississippi State Medical Association in 1908:

"I believe, yea I know, that the physicians as a whole do more real charity than all of the other professions together. They stand ready at all times, day or night, wet or dry, hot or cold, to respond quickly to calls of distress. By their unselfish devotion, their untiring service to the sick and suffering they have forced themselves into the inner-circle of the affections of every home in this land. Yet, with the twentieth century a new era has dawned and a new order of things must be put into operation."

The keynote address at that State Meeting was given by a Dr. McCormick of Bowling Green, Kentucky:

"Ours is the most humane of all of the callings of men, involving daily devotion to and contact with the sick and suffering and the duty of life saving. It is for the same reason that our profession does more actual Christian charity every day and every year than all of the other people put together."

As we now move to the final years of the 20th century I would agree with those physicians. It is estimated that American physicians provide free and uncompensated

care amounting to \$11 billion annually. Indeed, as we have approached the 21st century a new era has definitely dawned and a new order of things must be considered and initiated. We in medicine have so very much to do.

It disturbs me that every single delegate seat is not occupied this afternoon. Hopefully, in the future we will have active competition for the privilege to represent the various counties at the annual meeting. We need all of the elected delegates to be here and to participate in active debate: rural health care, Medicare, Medicaid, government affairs at the state level, public health services, legislative activities statewide and nationally. Our AMA representatives need your direction. You must remember they represent each Alabama physician.

Our future leaders will have to come from each region of our state and truly represent all segments of the medical community. We must impress upon the various county societies that it is their responsibility to elect qualified, interested, and actively practicing physicians to lead us into the 1990s and beyond. Our county presidents, our censors, and members of the Board of Medical Examiners should be down in the trenches each day. They need to share our concerns, fears, and our frustrations. They should feel the weight of the oppressively heavy bureaucratic load. Only men and women with the above qualifications can effectively respond to the problems of each of our members.

Selecting Leaders

We need to push physicians with leadership potential into the various levels of our chain of command. Perhaps our Nominating Committee could be appointed two years in advance of our state elections. It would be appropriate to arrange interviews with the various candidates during our Annual Session the year before their pending nomination. Powerful "behind the

scenes" leaders should be on these committees contributing to the open and frank discussions thereby ensuring that only the best candidates receive their nomination. An open forum encouraging vigorous debate is absolutely necessary as we proceed through the restrictive entanglements of the 1990s and enter the 21st Century. Somehow, a majority of physicians must contribute to the decision-making process and we must avoid being directed by a limited number of well-intentioned individuals.

At the offices of the State Association the welcome mat should be in place at all times. Ease of accessibility to the various levels of the State Association is of upmost importance. It must be a two-way super highway, wide-open, fast, effective, avoiding unnecessary delays. Physicians want action while the problem is real and troubling them. Delays in action are costly in dealing with these changes which continually affect the physician emotionally and financially. The way we receive someone as he or she approaches the State Association is extremely important. One disgruntled member, who perceives that we are not listening or not really interested, can foul the machinery that we desperately need to keep our State Association functioning smoothly and moving forward.

The nuts and bolts of a strong Association are in place. Our Association must be nurtured and guarded from abusive outside activity. However, the State Association should be strong enough to weather the multiple storms of the future and at the same time not reveal any outward signs of wear. During these very troubling times this Association must be perceived as a source of strength by all physicians. A difficult task! But if we can enlist men and women who are well qualified and are above reproach this can happen.

Members of the medical community are, by their very nature, somewhat skeptical and need to be constantly reassured that the system is fair and working for all physicians in every part of the State. A small "slip" will lead to extensive damage. The most recent example was that involving the executive vice-president of the AMA. However, we should rest easy in Alabama with men like Dr. Earl Riley, the Chairman of the Board of Censors, and Mr. Lon Conner, our Executive Director, standing at the helm of the Alabama State Medical Association. Great care will be necessary as they step aside in the future and their successors have to be selected.

The work load for your Censors and the Board of Medical Examiners is expanding rapidly. The anti-trust restrictions and the legal environment in which they work is difficult for many physicians to comprehend. The scope of their activities, their increased responsibility, the significant increase in preparation for each meeting have definitely changed during the past few years. These demands will continue to

increase as we move through this decade. As with any other group of elected officials, our members expect and deserve quality representation. On the other hand, donating two full practice days each month plus countless hours of preparation must be adequately compensated as the screws tighten and medical practice competition increases. To simply "cover" the expenses of these men and women, at least in my opinion, is no longer acceptable. We need a careful study in this area — we should not charge our leaders a "fee by default," while they serve us during these tumultuous times. I would hope that an appropriate decision regarding this situation could be reached in the very near future and this inequity could be corrected.

Young Physicians

The real strength of any organization is the constant infusion of new members with new ideas to help develop positive solutions to the many problems facing physicians today. The Young Physicians Section has grown primarily because of a nucleus of dedicated, hard working, unselfish young men and women. I am not certain that we at the state level have done all that we should do to ensure their continued growth and active participation. We need to work with this group more actively and give them the opportunity to participate, to voice their concerns, and to become actively involved in the decision-making process which will profoundly effect their careers and the delivery of health care to the citizens of Alabama.

Perhaps, a non-voting seat on the Board of Censors for a different young physician each year would be helpful. This physician could participate in the discussion of matters effecting all physicians and could contribute while learning about the inner workings of our State Association. This same individual could also serve as a direct link between the Board of Censors and the Young Physicians Section. In turn, this should give us some qualified individuals who could become informed and productive censors at a later date in their career.

Our retired censors and past leaders have a wealth of knowledge that could only have been gained by having been involved and struggling through divisive times together. Experience can only be gained by struggling with the decisions and living with the outcome, whatever the results might have been. This talented group would be willing to contribute and I believe they will if they are given the appropriate opportunity. We do not have time for "reinventing the wheel" or traveling along dead-end streets.

As with any quality corporation or business there needs to be a constant concern for the future growth of that organization. Early decisions must be made to avoid wasting monies and to ensure continued strengthening while adapting to the constantly changing world. We need a very active medium and long-

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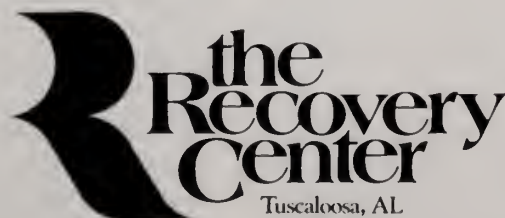
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range planning committee. The current Board of Censors is truly strapped with demands to keep us moving through the present times without incident. I believe a long-range planning committee could be composed of some of the past leaders that I mentioned above, some of the current censors, and some of the young physicians. Battle-scarred but experienced leaders like Dr. Bill Wright, Dr. Earl Riley, Dr. Bill Leitner, Dr. Julius Michaelson, and many, many others should blend their thoughts with the current leaders while trying to avoid excessively restraining the innocent enthusiasm of the younger physicians. An annual report from a group like this to our Censors and to this body, in my opinion, could be extremely beneficial.

Warning to Reviewers

With the National Practitioner Data Bank looming in the immediate future, our hospital review committees and state PRO physicians must be even more diligent and careful as they are called upon to review a physician's activities. Seemingly insignificant actions can result in lasting consequences for any Alabama physician. The Data Bank information will be entered with indelible ink. It cannot be removed—only modified by a few choice sentences.

Our Impaired Physicians section must become second to none. Physicians in need should be able to participate in this system at any time. Appropriate professional help must be available at a moments notice. Necessary follow-up with skilled professional care is mandatory. Your Board of Censors, along with the Board of Medical Examiners, has been working diligently to ensure that the physicians, as well as their patients, are protected appropriately. Serving on the Board of Medical Examiners helps one become acutely aware of the need for a well run dependable assistance program.

I am convinced that your AMA dues are worth every penny. Congressional subcommittee and committee activities need daily monitoring. We must know which subcommittee's actions directly and indirectly effect medicine. We need to know the key committee members and the appropriate way to communicate with these men and women. Frequently the AMA is our first and only line of defense against ever increasing bureaucratic involvement. We have a strong delegation. We must be thoughtful and diligent as we elect our AMA delegates in the future.

Try to envision all of the problems that the Massachusetts' physicians are now facing. Their problems can be directly attributed to the actions of their governor and state legislature. Participation now in ALAPAC and MASA by all Alabama physicians is absolutely necessary. We must prevent fires from starting rather than continually running around and trying to put out blazes that are already out of control. Our legislative staff led by Mr. Whitaker, is doing an excellent

job but they need for us to provide the "necessary equipment" (people, time, money) if they are going to be successful. Your activities in 1985 and 1986 gave us credibility as participants in the legislative process but we have only anti-ed. Like it or not we must remain players in a high stakes game— not for monetary gain but to ensure freedom to practice medicine as we were trained to practice medicine. We must blunt the efforts of so many entrepreneurs who are trying to become physicians without even seeing the inside of a medical school or a hospital. Our vigilance and participation in the state legislative activity is vitally important as wave after wave of would-be physicians approach that body.

Mutual Assurance

Since its inception in 1976, Mutual Assurance has grown into a well run and respected company. The AM Best Company has continually given Mutual Assurance extremely high ratings. We need to thank Dr. W. T. Wright, Dr. Derrill Crowe, and so many others for the excellent manner in which this company has been organized and subsequently directed. Thankfully, we have not followed so many other states' "bedpan mutuals" into the dark pits of bankruptcy.

Perhaps the most successful activity of your Association this past year has been the formation of the Third Party Grievance Task Force. Its activities have been expanding rapidly. The insurance carriers have worked with us regularly. The strong representatives sent to the conference table by Blue Cross and Blue Shield have been extremely helpful and have assured the success of the activities of this Task Force. Recently we have met with AQUAF and Complete Health.

We plan to meet with the State Insurance Commissioner in the very near future. We are ready and able to discuss problem areas with any one. This committee gives the individual physician a place to turn when a problem involving the insurance industry simply cannot be resolved. This Task Force evolved from the initial work of the Jefferson County Medical Society under the leadership of Dr. Goldstein. Using their basic ideas we restructured and adapted their program for the entire State Association. However, ours is not a physician advocacy program but rather a problem-solving program. This idea has limitless potential.

My goal this year has been to strengthen our State Medical Association. I have tried to "reach out" to our members and specifically to the various specialty societies. We must realize that the majority of those members are, after all, members of our State Medical Association. An organizational meeting for this group was held in January 1990. The meeting was extremely positive. The enthusiasm was contagious. I left that meeting believing that we will indeed find ways to work together, communicate better, and in turn insure an even stronger State Medical Association. The leaders of each

specialty group are dependable, interested, and ready to proceed.

Beyond Prophecy

In my wildest dreams I could have not imagined what would happen to medicine during the past two decades. As I entered private practice in 1972 it was enjoyable and very satisfying. I now realize I was practicing in the eye of a raging storm that was all about me. Practicing medicine has been a wonderful privilege. After we somehow pull out of this screaming nosedive I think the future for American medicine will be brighter and probably more tranquil. Due to unbelievable technological advances the future for our patients will definitely be better as long as they have their own physician and are somehow required to participate in at least partial payment for their care. In that manner they will be less likely to abuse the American Medical System. Our delivery of health care has been the best, is now the best, and with dedicated concerned American physicians leading the way it will remain the best. The quality of care has not been the issue with the American people. Twenty years ago the American automobile was the gold standard. By letting quality slip, just a little, the perception is that foreign automobiles are now the best. Fortunately, people continue to come to America from every country for complicated medical care. We simply cannot stand by

and permit the federal bureaucracies to destroy this lofty standard that has taken over a century to build. Americans respond well to challenges! American physicians are no exception. As I am sure you can recall, obtaining your M.D. degree was extremely demanding. The years of study were expensive financially, physically, and emotionally. We have managed to endure the unbelievable challenges of the 1980s and I believe we have sufficient resolve to endure whatever we might face in the 1990s.

In spite of all of the physician bashing that takes place in the legislative hearings, the courtrooms of America, or in the media, much of what those physicians said in 1908, almost a century ago, remains true today. We need to be reminded that we as a profession are really getting the job done. You should remain proud of your individual work and of your profession in spite of all the rhetoric. You should continue to struggle to overcome the hardships which must be endured while practicing medicine in America in the 1990s. In my humble opinion it is truly worth your continued effort.

On the other hand, we are privileged to touch and affect the lives of so many people from all walks of life. We simply cannot take American medicine for granted any longer. The whole world is changing – why shouldn't we expect changes in the way we practice medicine. Gradual, purposeful, structured, considered

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change would be well tolerated by all. However, the destruction of medicine, which so many are demanding, based purely on the bottom line, must be fought with every bit of energy that we can muster.

There are many positives and we can work with all segments of society for a beneficial change. We have to be certain that we will be represented any time the future of American medicine is discussed or decisions are being made. Frank differences of opinion have always been a part of the democratic process in America. That is the way it should be, and it is a part of the strength of our great country. I believe the people of America will always listen to us if we do our best to stay up-to-date, treat our patients fairly and with compassion, and do our part to help our communities grow and prosper.

Healthy Debate

Among honest and intelligent men here will always be differences of opinion. Fair, clean debate will be appropriate and healthy. However, we must not permit a single individual or a single issue to divide this House. We must all remember that there is solid ground somewhere in the middle. If we are to continue to strengthen and be effective we must allow all to be heard and then be willing to accept appropriate compromise which will insure reasonable solutions to our problems.

There are too many people to thank for helping me this past year. Lon Conner and his staff have been

patient, supportive, and professional.

Dr. James Green, my vice-president, has given far more than I. When Jim was in Montgomery each month his office was closed, as he is in solo practice. Jim, I simply can't thank you enough.

Each of my partners has carried a portion of my load during my travelling, committee activities, and state meetings during the past five years. I thank them for this support and feel ready to pick up my full share of the load once again.

Finally, for whatever reasons, the State Medical community has given me opportunities for leadership since the beginning of our Tort Reform battle in 1985. I have been received warmly in every corner of this State. I have made some new and strong friendships. To have been given the privilege to serve as president of the Medical Association of the State of Alabama is something I shall never forget.

To lead, even briefly, the 5,000 men and women of this State Association has been an unbelievable experience. I have given you my very best. I am certain it was not enough for some of you. But if you help Riley Lumpkin, and in turn Bill Lazenby, as much as you have helped and supported me, they will do an outstanding job and this State Medical Association will continue to strengthen and move forward.

It is nice to step aside now and make room for our future leaders and support their positive efforts during these eventful times. □

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Deferred and immediate annuities are attracting attention. Why? Their tax advantages, competitive fixed rates, convenient income payout options, minimum guaranteed rates and dependability are compelling.

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What is an annuity for?

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Are annuities safe?

Except for a particular type of annuity called a variable annuity, the funds you put into an annuity are guaranteed by the life insurance company issuing the contract. Life insurance companies are required by law to maintain sufficient reserves to meet their policyholder obligations. This is called the Legal Reserve System. Assuming you purchase your fixed annuity from a financially strong, well-managed company, there is little reason to be concerned about the safety of your principal.

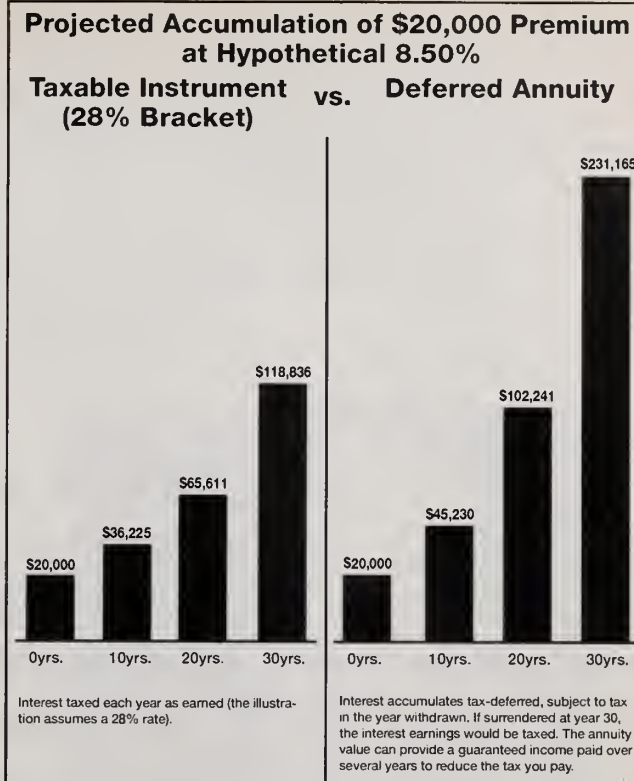
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A rule of thumb is that, the closer you are to retirement, the more conservatively you should invest your retirement savings.

Conversely, conventional wisdom has it that younger people saving for retirement may be able to assume somewhat more market risk.

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Year	Scenario A	Scenario B
1	+20%	+8%
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3	+10%	+8%
4	-17%	+8%
5	+10%	+8%

The answer is that, after five years, both scenarios will result in about the same balance: accepting market risk, especially when it comes to retirement sav-

ings, isn't always prudent. The real beauty of a deferred annuity's interest rate is that earnings accumulate tax-deferred. Consequently, you need a higher rate of return on a taxable instrument to match the tax deferred earnings of a deferred annuity.

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Duff and Phelps rates companies for their claims paying abilities. You should accept no less than an A+ rating from them.

Standard & Poor's also rates insurance companies on their present and long-term prospects for being able to pay out claims to their policyholders: an A rating is the recommended minimum from this authority to assure your choice has sufficient financial strength to pay out your future retirement check.

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Intrapulmonary Bronchogenic Cyst: Spontaneous Dissolution?

*Myung S. Shin, M.D.**
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*Kang-Jey Ho, M.D., Ph.D.***

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Abstract

A well-demarcated, non-calcific, solitary pulmonary nodule was initially discovered 3 v2 years ago on a chest radiograph in a 43-year-old woman with recurrent acute bronchitis. The nodNle had been stationary with minimal change in size until the last radiographic examination which showed total disappearance of the nodule. A thin-walled, air-filled cyst was, however, demonstrated by computed tomography at the same location. The nodule was believed to be an intrapulmonary bronchogenic cyst which developed communication with airway with discharge of its watery content, leading to its pseudo-resolution.

Spontaneous resolution of a cystic lesion has been frequently described for pancreatic pseudocysts, pulmonary pseudocysts of newborn infants, and lymphoceles after lymphadenectomy for prostatic cancer or after renal transplantation (1-4). Such occurrence is extremely rare for true epithelial cysts. We have previously reported spontaneous radiographic resolution of a pericardial cyst in a 65 year-old man(5). Recently Martin et al (6) have described spontaneous disappearance of a bron-

chogenic or enteric cyst in two children. Reported here is a patient with an intrapulmonary cystic lesion which disappeared completely from conventional chest radiography 3-1/2 years after its initial discovery. A thin-walled cyst filled with air instead of liquid was, however, detected by computed tomography (CT) at the same location. Radiographic disappearance of a solitary pulmonary nodule might not, therefore, represent the true resolution of the lesion.

Report of a case

A 43-year-old woman with a history of childhood asthma, chronic paranasal sinusitis, and 30 pack-year of cigarette smoking has been suffering from repeated episodes of acute bronchitis with productive cough from time to time. A well-circumscribed, non-calcific, round nodule, measuring about 1.5 cm in diameter, was found in the left upper lobe on a chest radiograph in November 1985 (Fig. 1A). There was no associated hilar lymphadenopathy, atelectasis, or pneumonia. The patient refused surgical exploration and the pulmonary nodule has been followed up closely thereafter. During the past 3-1/2 years several episodes of acute bronchitis occurred. Each time the patient was treated with antibiotics with complete abatement of the symptoms but the left upper lobe nodule persisted. The lesion seemed



Figure 1A



Figure 1B



Figure 1C

to be somewhat smaller in May 1987 (Fig. 1B). However, a thoracic CT done in November 1988 revealed that the nodule remained the same size as originally discovered (Fig. 2). On CT the nodule was round, homogeneous, sharply defined, smoothly margined, and not calcified. The surrounding pulmonary parenchyma showed no evidence of retraction, consolidation, or other abnormality.

Again in March 1989 the patient was treated with antibiotics for recurrent bronchitis. The symptoms subsided after the treatment. Surprisingly the left upper lobe nodule disappeared entirely from the chest radiograph (Fig. 1C). In order to confirm such spontaneous resolution of a pulmonary nodule, another thoracic CT was performed. To our surprise again the lesion remained in the same location which was in fact a thin-walled cyst filled with air instead of fluid (Fig. 3). A lesion missing from the conventional radiograph was thus re-discovered by CT.

Discussion

A solitary nodule or coin lesion in the lung parenchyma detected on a chest radiograph could be a malignant or benign neoplasm, a granuloma, an abscess, or a cyst (2,8). The solitary pulmonary nodule in the left upper lobe of the present case was round, well-circumscribed, non-calcific, and stationary for at least 3-1/2 years. Such a lesion is usually benign and can be a slow-growing neoplasm, a non-growing hamatoma, or a fluid-filled cyst (8). The

CT done in March 1989 not only re-discovered the lesion but also gave away its true nature: a thin-walled, air-filled cyst (Fig. 3).

The initial CT done in November 1988 was reexamined retrospectively for the density of the cyst content which was not evaluated initially. The content of the left upper lobe cyst was homogeneous and had an attenuation coefficient of 10 Hounsfield Units, similar to that of water. A slowly growing neoplasm always has a higher attenuation number (7, 8) whereas a pulmonary hamatoma may contain fat alternating areas of calcification and is thus inhomogeneous in density (10). If the density of the pulmonary nodule were studied initially, the cystic nature of the lesion would be easily confirmed.

Cysts of foregut origin include bronchogenic and enteric cysts (11). Almost all enteric cysts are confined to the posterior mediastinum (11). In those bronchogenic cysts arising from accessory lung buds from the foregut are found in the anterior mediastinum whereas those arising from secondary buds from bronchial tree are located within the lung substance (12). Therefore, the cyst in the left upper lobe in this patient is most likely an intrapulmonary bronchogenic cyst instead of an enteric cyst. A bronchogenic cyst is unilocular, lined by a bronchial epithelium, and may contain watery fluid, mucus, or rarely purulent material. Although some bronchogenic cysts do have a high attenuation number due to calcium deposits (13, 14), most of such cysts have a CT attenuation coefficient in the range of - 3



Figure 2

to 20 Hounsfield Units as demonstrated by the present case (13).

A bronchogenic cyst, unlike a lung abscess, does not, as a rule, communicate directly with the airway and is asymptomatic or minimally symptomatic, only to be detected incidentally on a routine chest x-ray examination. The cyst in our patient was stationary radiographically for 3-1/2 years until a communication between the cyst and airway was established, leading to the discharge of its watery content and disappearance of its nodular shadow from the chest radiograph. Although the exact mechanism for development of such a communication is not clear, the cyst must be in an intimate contact with the airway. It is possible that in the future such communication may be interrupted again and a fluid filled cyst may reappear on the chest radiograph.

The present case demonstrates that CT is very useful in evaluation of a solitary pulmonary nodule or cyst and that radiographic disappearance of such a nodule may not represent the true resolution of the lesion. □

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Figure 3



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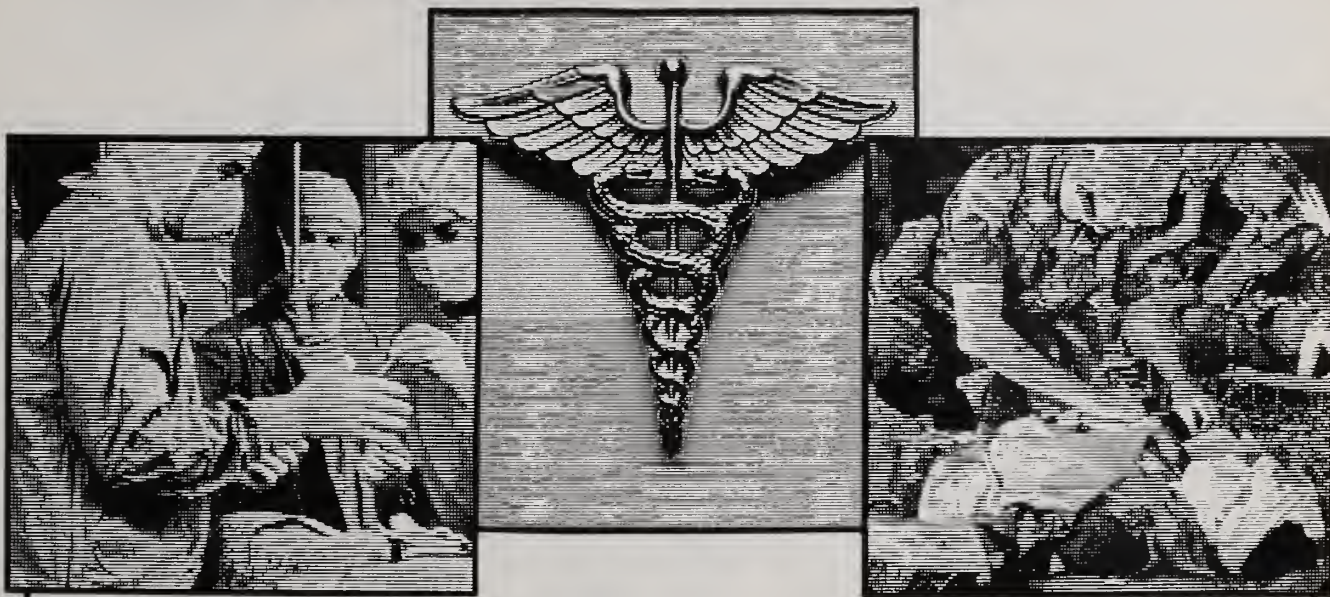
Legends for Figures

Fig 1. Chest radiographs of the patient taken in November 1985 (A) showing a solitary nodule in the right upper lobe upper: Posteroanterior view, lower: lateral view, in May 1987 (B) a somewhat smaller nodule, and in March 1989 (C) disappearance of the nodule.

Fig 2. Thoracic CT taken in November 1988 revealing a round, sharply demarcated, homogeneous nodule in the left upper lung.

Fig 3. Thoracic CT taken in March 1989 showing a thin-walled, air-filled cyst in the left upper lung which seems to be in an intimate contact with a bronchus.

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Serial Arsenic Poisoning: Two Alabama Cases

*Joseph H. Embry, M.D., J.D.
and H.C. Walls, B.S.*

ABSTRACT

Arsenic poisoners are predominantly women. The occasional localization of cases suggests the inspiration may result from the publicity of earlier cases or word of mouth. Two recent cases of serial arsenic poisoners in Alabama are presented with discussion of the psychodynamics of the murderers.

Introduction

The recent cases of Charles Albanese¹ and Dr. Michael Swango demonstrate that serial arsenic poisoners are by no means exclusively females. Two cases are in the older literature in which women were murdered by their husbands by the introduction of arsenic into the vagina after coition.² Women have been long identified in literature³ as poisoners, however, and many notorious female serial arsenic poisoners have been prosecuted.⁴ Of the 68 women who were hanged in Britain between 1843 and 1958, when capital punishment was abolished, 37 were poisoners, predominantly by the use of arsenic.⁵ Seven of these were serial poisoners. Of interest, 11 of the 37 lived in or near either Ipswich or Boston, England. An epidemic of arsenic poisoning occurred in a small region in Hungary by peasant women, who kept their secret until 1929, when many of them were tried for poisoning their husbands and other family members.⁶ The estimated number of victims was 165; however, the government placed a 20-year limit on exhumations.

Case 1

Mrs. H. was born near Anniston in 1933.^{7,8} Her parents doted on her, their only child. She was partial to her father and jealous of her mother. Her father was described as sweet-natured, but unreliable and would disappear for months to visit his identical twin brother, who moved to Texas after Mrs. H.'s father was married. Mrs. H. sometimes fantasized that she had a twin. She was attractive and she was the first in either of her parents' families to graduate from high school. She married Mr. H. in 1951, when he was 22. She became an efficient executive secretary to at least five of Anniston's business

leaders. Mr. H. worked his way up from millworker to assistant superintendent in his plant. Mrs. H. appeared to be the dominant figure. They had two children and were considered by many to be a model family.

Of significance, a notorious arsenic poisoner, Nanny Doss, "the giggling grandma," who murdered four husbands with arsenic before she was arrested in 1954 in Oklahoma, was born and reared a few miles from Anniston in the same town, tiny Blue Mountain, where Mrs. H. lived until she was a teenager. In fact, Nanny had worked in the same mill where Mrs. H.'s parents were working and where Mrs. H. was working as a secretary when Nanny was arrested. Her story was on the front page of the Anniston newspaper for a month and her memoirs were in *Life* magazine. Oklahoma developed a statewide Medical Examiner system due at least in part to her offenses.

Mr. H. was poisoned with arsenic in 1975 for about six months before he died. He had weight loss, vomiting and diarrhea during that time. He began to have episodes of confusion and disorientation. He was in the hospital one week before he died. Before his death he told his sister that Mrs. H. had given him injections in the hospital, allegedly authorized by his doctor. The clinical and autopsy diagnosis was infectious hepatitis. Mrs. H. received \$30,000 in life insurance. She bought her mother-in-law a diamond ring, her son and his wife a washing machine, and her daughter an automobile. She bought furniture, jewelry, new clothes and a new Oldsmobile for herself.

She had many problems in the next few years, including bouncing checks, unsolved burglaries, episodes of arson, threatening telephone calls and a threatening note, all probably instigated by herself. Her daughter-in-law was hospitalized four times for severe nausea and vomiting of undetermined cause during this period. During the fourth hospitalization she had a miscarriage, after which she and her husband moved to Georgia.

In 1979, Mrs. H. began to poison her 19 year old daughter, who was hospitalized four times in Anniston for vomiting and diarrhea and ultimately lost twenty-five pounds. She suggested to her daughter's physicians that her daughter had psychiatric problems. She developed numbness in her hands and feet. Mrs. H. had her hospitalized in Birmingham. Her diagnosis was anorexia nervosa. Her peripheral neuropathy progressed until she could walk only with great difficulty.

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She weighed eighty-one pounds.

H. gave her injections in the hospital and when this was discovered by her sister-in-law, the same woman who knew that she had injected Mr. H., her physician was informed and the diagnosis of chronic arsenic poisoning was made. Mrs. H. had tried desperately to pay the premiums on her daughter's \$40,000 life insurance policy. Arsenic residue was found in a vial in her purse when she was arrested and a bottle of Cowley's Rat Poison, 1.5 percent arsenic trioxide, was found in Anniston with her possessions. Her husband was exhumed and arsenic was found in his hair, nails and in other organs, which remained from the first autopsy. His liver had numerous mitotic figures, a feature seen occasionally in chronic arsenic poisoning.

Mrs. H. was charged with murder and attempted murder. Released on bond, she jumped bail and made her way to Fort Lauderdale, where she met and soon married her second husband. He was an eccentric introvert, who had cut his ties with his family, except for a brother, who urged them to move to New Hampshire with him and his wife. After a year they did move to tiny Marlow, New Hampshire. They had been married three years when Mrs. H. went to Texas, lost thirty pounds, and, after three months, dyed her hair blond and returned to Marlow as Teri Martin, her twin sister. She told her husband that Mrs. H. had died. She had prepared him with the story that she had an incurable disease and a twin sister and he believed her, as did some of her former co-workers. She filed a fake obituary in the local newspaper. Some of her co-workers were suspicious of the hoax and initiated an investigation. Unfortunately for her, the name Teri Martin was very close to an alias of another fugitive. She was picked up by the state police at her new job in Brattleboro, Vermont. She was tired of running and told them who she was, apparently assuming they knew. She waved extradition and in 1983 was brought back to Anniston, tried and convicted of murder and attempted murder.

Mrs. H. denied she poisoned anyone. She was sentenced to a life term in the state prison for women. Routine psychological testing revealed a moderate elevation in category four (Pd) of her MMPI, indicating Psychopathic deviate personality type. All other categories were normal, including those designed to detect deception. She was a model prisoner and was eventually granted furloughs. She disappeared in Anniston on her first three day pass in February, 1987. She left a note for her husband, who had followed her to Alabama, saying she was going to Canada with a friend named Walter. Instead, she apparently walked along the railroad tracks to Blue Mountain, where she was found, barely conscious, trying to break into a house the next day. The temperature had been in the 30's and it had rained. She died on the way to the hospital at age 53 of hypothermia.

Case 2

Mrs. G. poisoned four adults. Her first (known) victim was her third husband. Mr. G. was a sixty-one year old white male, who died in 1978 in the hospital in Decatur. He had lost twenty pounds and had been hospitalized briefly two months prior to death for nausea and vomiting. He had mental confusion, vomiting with chest pain and diarrhea for three days before his final hospital admission. He died on the third hospital day. His final diagnosis was myocardial infarction. There was no autopsy. His wife had stayed with him in the hospital. He had \$10,000 life insurance. He was exhumed in 1984 and toxicological analyses revealed chronic arsenic poisoning.

Mrs. G.'s next victim was her murdered husband's sister, a fifty-nine year old woman who died in 1979, eight months after her brother. She and Mrs. G. lived in the same apartment building. She was referred to a Huntsville hospital for nausea and vomiting of about one week duration. She was semicomatose and in shock with renal failure. Her BUN was 140 and her serum amylase was 700. She died on the day of admission. The diagnosis was pancreatitis. The family did not want an autopsy. She was exhumed in 1984. Toxicological analyses revealed arsenic poisoning.

Mrs. G.'s next victim was a fifty year old restaurateur. Mrs. G. was his waitress and friend. He was admitted to the hospital September 2, 1981, for profuse diarrhea, nausea and vomiting. He had a history of alcohol abuse. His blood pressure on admission was 60/0. He was discharged but readmitted September 20 with the same symptoms. He was confused and complained that someone was poisoning him. He was transferred to the psychiatric service on the tenth hospital day. He was discharged later and died two weeks after that in December. He was exhumed in 1985. Toxicological analyses revealed high levels of arsenic in his hair and toenails. No arsenic was found in his liver. A low level was in the kidneys.

Mrs. G.'s last victim survived to testify against her in court. He was a fifty-six year old widower who had a grocery store. He sometimes stayed with Mrs. G. He had intermittent vomiting and diarrhea for a year. He had been hospitalized after seven months in June, 1984, for diagnostic tests. He was hospitalized in Huntsville in November. He had lost twenty pounds. He was confused and disoriented on admission, though he answered questions appropriately most of the time. He developed severe stocking glove peripheral neuropathy on the eighth hospital day and the diagnosis of arsenic poisoning was made by analysis of his hair and urine. Arsenic residue was found in a Gatorade container, a bowl and a dish recovered from his house. He defended Mrs. G. initially, at her request, but was persuaded to testify against her.

Mrs. G.'s fingerprints were on the Gatorade container, but she denied any knowledge of the poisonings during her interrogation. She said that she and her last victim had been receiving threatening notes and

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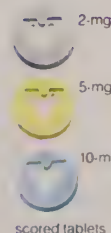
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telephone calls. The sheriff persisted and, after being shown a photograph of her husband's disinterred grave, she admitted that she had an evil personality who came out when she was alone. This person would choke her if she did not do the things she ordered. She said this person had been with her all her life, but had been benign until she was in an automobile accident in 1978. She eventually admitted the poisonings, but said the evil personality had been responsible.

The investigators and psychiatrists were skeptical. Mrs. G. had never mentioned such a personality to her family prior to her interrogation. Her subsequent preoccupation with the evil personality made her appear almost psychotic. There was still some suspicion of malingering after four months in the state mental hospital in Tuscaloosa, where she underwent psychiatric evaluation. Episodes of threatening notes were reported to have occurred also in 1961, during her first marriage. (Her first husband apparently died as a result of complications of surgery for repair of an abdominal aortic aneurysm. Her second marriage was annulled by her husband very soon after the marriage for unknown reasons.) Her MMPI appeared to be consistent with the clinical impression of atypical dissociative disorder. Her MMPI was characterized by "tension, anxiety and discomfort with a tendency to deny and repress negative thoughts and emotions with little understanding of the effect of her emotions on her well-being; a tendency to be highly self-critical with strong needs for the affection of others but feeling unworthy of this affection; feelings of unreality and even delusions; and frequent physical complaints, including blurred vision, dizziness, numbness of hands and feet and headaches.

Overall, it is a mixed pattern of neurotic and psychotic symptoms and is relatively rare. Her father reportedly abused alcohol; there was no specific history of childhood trauma. She had severe headaches. She described at least two instances of "waking up" and being in strange places and not knowing how or why she came there. The psychiatrists were impressed by the fact that she had had a nervous breakdown in 1958 and that she did not exaggerate her symptoms clinically or in her MMPI. Her insanity defense failed, however, and she was convicted of attempted murder and two counts of murder, sentences to run concurrently, at age 53. She has adjusted well to life in prison.

Discussion

Female serial murderers have been characterized as egoistic machines, while males are usually sexual psychopaths.⁵ Generalizations are difficult due to the low frequency.⁷ One must be impressed by the control exercised by the slow poisoners over their victims, "since there is no greater power over another person than that of forcing him to undergo suffering without being able to defend himself...the very essence of the sadistic drive."¹⁰

The psychodynamics of Mrs. H. and Mrs. G. were very different. Mrs. H. had a defective superego. Charming, intelligent and manipulative, she had little anxiety or guilt. She was ambitious and assertive with no compulsive need to hurt others. Her basic problem was a need to have her own way, and an inadequate conscience, which failed to inhibit her criminal behavior.

By contrast, Mrs. G.'s seemingly motiveless poisonings were apparently accomplished by an assertive alter personality, who provided her with a means of control in her relationships. Dissociation is "the segregation of a group of mental processes, separated off from consciousness, but functioning as a unitary whole, as if they belonged to another person. This, when greatly elaborated, may lead to a double personality, but only if the dissociated complexes displace the normal consciousness, becoming themselves conscious."¹¹ Multiple personality disorder is rare,^{12,15} and controversy still exists regarding its incidence.¹⁶ "Malingering presents a particularly difficult diagnostic problem" in the differential diagnosis of multiple personality disorder.¹³ The contested assertions in certain criminal cases, such as that of serial murderer Kenneth Bianchi (the Hillside Strangler), has contributed to the skepticism.¹⁷⁻¹⁹

Conclusion

Arsenic poisoning, usually homicidal, continues to occur sporadically. Although it may be inherently difficult to do so in the usual clinical circumstances, physicians should consider the possibility of deception by friends or relatives of patients; that is, they should, in forensic pathology parlance, "think dirty."²⁰

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The Year Progresses

It seems only yesterday that I was installed as President of the Auxiliary to the Medical Association of the State of Alabama, but now it is time to reflect on the past year, see what progress we have made, and suggest some things that can be improved.

Medical auxiliary members are enthusiastic, interested and interesting, and are certainly trying to making this old world a healthier, happier place to be. For the most part, they intend to help in any way they can to make their physician-spouses healthier and happier, too!

This year I have visited Auxiliaries in Calhoun, Colbert, Etowah, Franklin, Jackson, Jefferson, Lauderdale, Madison, Marshall Montgomery-Autauga, and Morgan-Lawrence Counties. I still have visits to make to Pickens and Talladega Counties. It is most enjoyable to travel around this pretty state of ours and visit county auxiliaries, seeing what each individual county has accomplished. The high intensity of civic involvement of Auxilians in projects that improve the quality of life for all citizens makes me proud to be one of them!

An owl has always been associated with wisdom and knowledge, so my logo has been an owl, and my theme has been "Knowledge First—Then Action!". Our Auxilians have gained knowledge through our workshops, and they have taken action on many different projects.

During last summer, we decided to start a spousal ALAPAC-AMPAC membership, and AMA mailed a letter that we wrote to all Alabama Auxiliary members. In 1988 we had seven members; in 1989, 87 members! AMA mailed a letter for us in March 1990, and, since this is an important election year in Alabama, we hope to double our membership in ALAPAC-AMPAC. AMPAC presents every two years, following the general election, the "Belle Chenault Award for Political Participation" to a member of state and national auxiliaries and of state and national PACS. This award, named for our own Mrs. John Chenault of Decatur, is the only AMPAC or AMA award we know about that is named for an Auxiliary member!

At our Fall Conference and Board Meeting in Birmingham Mrs. S. Bruce Gerber, Southern Regional Vice-President, was our representative from national and

brought us news about the AMA Auxiliary. Dr. Anderson M. Morris, cardiologist, spoke to us on "Campaign Against Cholesterol", which was our main state-wide health project this year. Workshops were held on AMA-ERF, Health Projects, Membership, Legislation, and ALAPAC-AMPAC. Most of us had a free cholesterol check at The Health Fair Store, a part of the Baptist Medical Centers.

Alabama was represented at Confluence I and II in Chicago by AMASA's President Mrs. John O. Hardiman, President-Elect Mrs. Charles Patterson, Nominated President-Elect Mrs. Stuart Bean, and nine County Auxiliary Presidents-Elect: Mrs. Oren Babb of Calhoun County, Mrs. Robert Mathews of Colbert, Mrs. Greg Windham of Cullman, Mrs. Thomas Pugliese of Etowah, Mrs. Ronald Orso of Jefferson, Mrs. Wendell Gaillard of Lee, Mrs. Benjamin King of Madison, Mrs. William Hall of Mobile, and Mrs. Ishwar Bhuta of Montgomery-Autauga. These are two and-a-half-day intensive leadership training programs sponsored by AMAA, held in September and February, consisting of sessions such as how to match members with positions to be filled, how to write it right, encouraging cooperation between Medical Societies and Auxiliaries, and using correct parliamentary procedures in meetings. Upon returning, the enthusiasm and knowledge that these delegates gain spread throughout the entire state! Enthusiasm is highly contagious, you know!

It was my pleasure to install officers of the newly reorganized Marshall County Auxiliary in October. We would like to have more county auxiliaries organized. If any of your spouses are interested, please have them contact one of our members, officers, or MASA Administrative Offices, and we will be glad to help them with the necessary procedures. There is strength in numbers, and we would like to have your spouses join us.

Our Winter Workshop and Board Meeting was in Montgomery, and we took advantage of the meeting of the Legislature to take to each member a white coffee mug with a red heart and A-MASA fired on the side, containing a packet of spiced cider mix, two small oat bran muffins, and a large button with a red heart jumping up stating "I Know My Number". Tied on with a red ribbon was a note card

with the Auxiliary's seal on it with the message "We care about your heart. Please 'Know Your Number', and act accordingly! Auxiliary, Medical Association of the State of Alabama". We want them to know that we are interested in their health.

At our Winter Workshop Sandra Wheeler, Director of Maternity Services, Department of Public Health, spoke to us on "Teenage Pregnancy"; Dr. William J. Tally, Chairman, Impaired Physician's Committee, told us of the background of the Impaired Physician's Committee, and we are supportive of this; and Richard C. Whitaker, MASA, spoke on legislative concerns. Our program at our dinner on Tuesday evening was "European Garden Styles", a very beautiful slide presentation by Dr. Ed Givhan of Montgomery. We had several dinner guests from MASA and MASA Staff.

Our International Health Project this year is a donation to the APSS Sight Clinic in Escuintla, Guatemala, where eye examinations, medicines, and surgery are available once a week to poor patients at no charge. Our co-chairmen Mrs. Eugene Bradley and Mrs. Arthur Stamler selected this project this year since my husband is an ophthalmologist, and I sincerely appreciate their thoughtfulness.

Although County Auxiliaries support our state and national projects, they still have time to handle special local health projects like Mobile's Camp Rap-A-Hope for young cancer patients, Madison County's Organ Donor Project, offered to tenth grade students enrolled in Driver Education, Jefferson County's Child Abuse Educations Committee's Puppet Show, presented in elementary schools, and many other projects to improve both physical and mental health of members of our communities.

To benefit AMA-ERF, the Auxiliary's only nationwide money raising project, many of our County Auxiliaries sent Sharing Cards at Christmas. Auxilians sold wrapping

paper, had bake sales, fashion shows, antique shows and sales, and similar projects. We think it is very important to help our medical schools with money for scholarship funds and for special projects. Our final total for AMA-ERF contributions is not known at this time, but at our Annual Convention at Perdido Beach we had a Silent Auction of articles donated by County Auxiliaries, in the hope that we can at least reach the level of giving that we had last year. Deans of Medical Schools of Alabama were presented checks at our AMA-ERF luncheon on Friday, April 6, to close our convention.

We are working hard on membership, but we may fall short of our last year's total of 2,129. When you read this, why don't you check to see if your spouse's dues are paid, and pay them if they have not been paid? We have until May 15 for dues to count toward this year's total. We need your help!

Mrs. J. Edward Hill, President of AMAA, was our guest at the Convention, and Dr. Alan R. Nelson, President of AMA, was the guest of MASA. Mrs. A. J. Campbell, President of SMAA, was guest speaker at our Doctors' Day luncheon on Thursday, April 5. We were pleased that the top officer of each group was with us at Perdido Beach.

I feel that we have had a good year, and have enjoyed my contacts with the Medical Association, your officers, the staff, and the printing staff. I thank you for your help and support. Working together, we can accomplish much more that either group can accomplish separately!

This is the end of the owl, but it will not be the end of the Auxiliary taking action based on knowledge, for Mrs. Charles Patterson of Anniston will be installed as Auxiliary President on April 6, 1990. She is most capable, and the Auxiliary will continue to improve under her leadership. I have pledged to help Antoinette in any way that I can, and I hope that you will do likewise! □

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Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed. Caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hypotension, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: **General:** **Impaired Renal Function.** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or induced effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release. The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucuronides, calcium-channeling agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters. There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed in utero to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of 14 C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION). Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: **Hypertension.** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed. If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg. The maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia. In patients with heart failure who have hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d. then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19380.

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Alabama Medicine

May 1990

Vol. 59, No. 11

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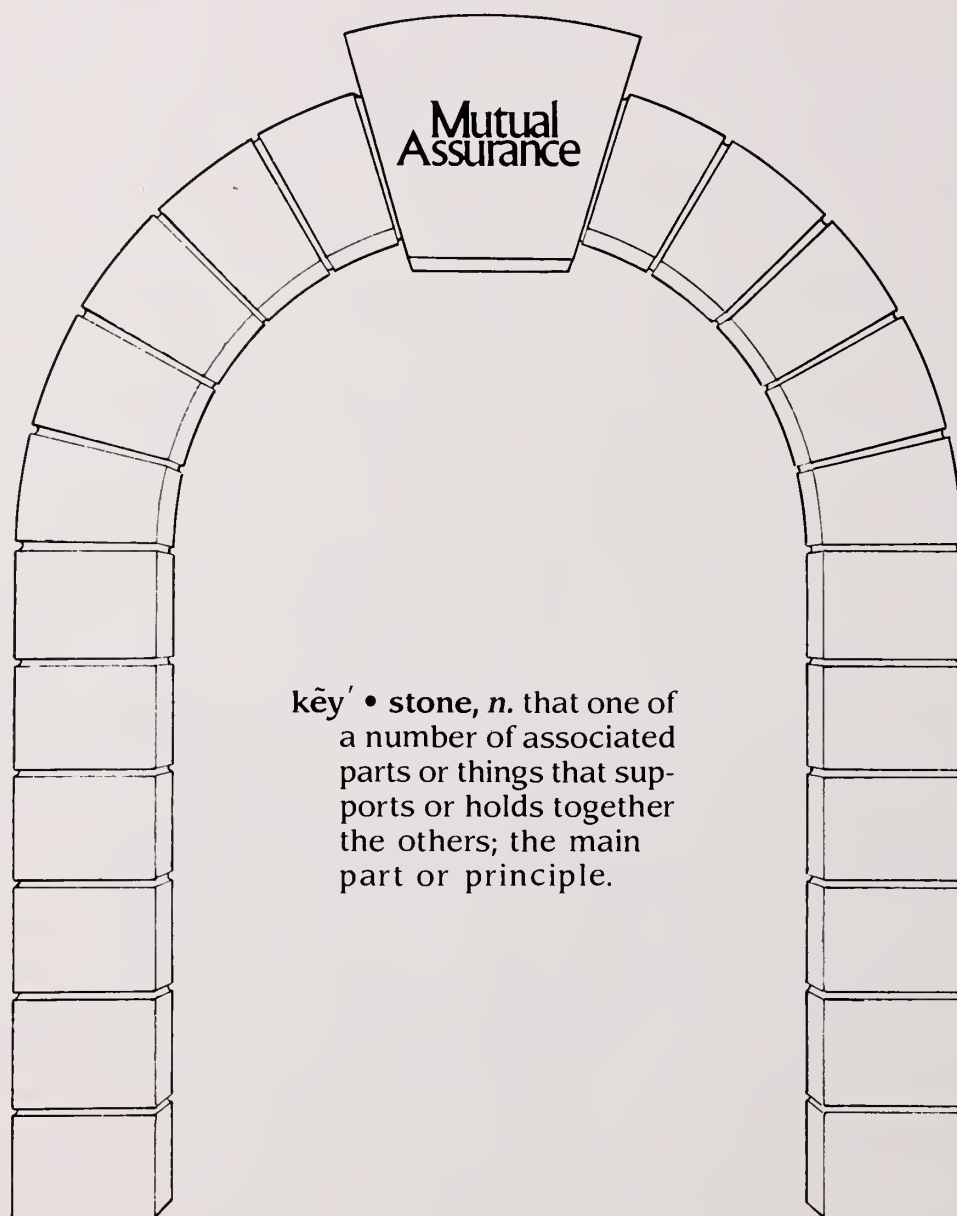
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

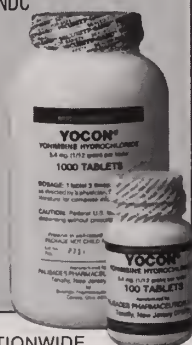
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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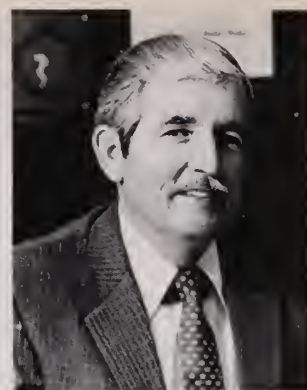
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Our Faceless Rulers

Bureaucracy, the rule of no one, has become the modern form of despotism.

So wrote Mary McCarthy, an astute observer of American trends, morals, manners and mores.

When we think of true despots, most of us call to mind the names of single individuals ruthlessly wielding enormous power by virtue of the accident of birth in a royal line or by usurpation as the result of revolution, intrigue or ghastly misjudgments by an electorate. We think of Hitler and Stalin in modern times, of emperors of earlier days.

We rarely think of bureaucrats as deserving of the same degree of condemnation as classic tyrants and dictators. To begin with, they are ordinary people who come from the same backgrounds as the rest of us. They are salaried drones who have achieved positions of enormous power. But, collectively, they are prone to despotism.

The evils of bureaucracy span the centuries. Only 40 years had passed after our own Declaration of Independence from the British despot when Thomas Jefferson saw a peril emerging in the young country: "The functionaries of every government have propensities to command at will the liberty and property of their constituents." Eight years later he was more specific: "I think we have more machinery of government than is necessary, too many parasites living on the labor of the industrious."

Just over a century later, in 1930, none other than Franklin Delano Roosevelt, two years before his own

presidential election was to greatly expand the U.S. bureaucracy, warned in a radio address:

"If we do not halt this steady process of building commissions and regulatory bodies...like huge inverted pyramids...we shall soon be spending many billions of dollars more."

Yet his New Deal embraced bureaucracy on a scale beyond the wildest dreams of the Sage of Monticello. Throughout World War II the continued expansion of bureaucracy was legitimized by the exigencies of global conflict.

After the war, Presidents Truman, Eisenhower, Kennedy, Johnson, Nixon and Reagan — all inveighed against government by bureaucracy. And still bureaucracy metastasized, even under its most intractable enemy, Reagan.

Now, in the last decade of the century, we have the spectacle of a Congress of weakened will and direction delegating ever larger chunks of the legislative process to more and more faceless, unelected and virtually untouchable bureaucrats in the far reaches of government. We have the spectacle of men and women far more concerned about their perpetuation in office than in actually serving as the decision makers of the people. They continue to abdicate their responsibilities wholesale to regulatory agencies, with little more than the pretense of effective congressional oversight.

The HUD scandal could not have happened had Congress done its duty, whatever the derelictions of the Executive branch. Congress had multiple warnings of HUD fraud and corruption. It did nothing, one reason

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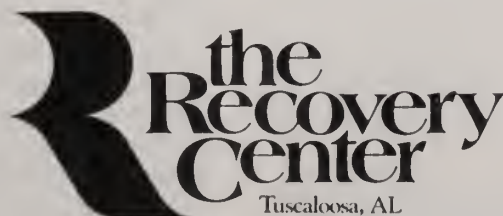
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surely being that so many of the high and mighty in U.S. politics were feeding at that trough.

The same congressional nonfeasance and malfeasance is evident all through the continuing revelations of the monstrous S&L crime against the people — the greatest financial disaster in the history of the country. Congress ignored the storm signals and the reports of flagrant fraud and downright theft. As a consequence of this abdication to the federal bureaucracy charged with S&L regulation, and now shown to have been involved in the incredible scandal, every one of us will share in the cost. By the beginning of the 21st century that bail-out may total \$500 to \$600 billion, perhaps even more, including interest.

Where was Congress when all this was happening? Too many of its members were beneficiaries of the colossal rip-off and the others were too busy perpetuating themselves in office to look.

Re-elections seem to have become the principal business of Congress, so far removed from the intent of the founding fathers, who envisioned an aggregation of citizens primarily devoted to other businesses and professions — agriculture, medicine, law, manufacturing and trade — who would spend a small fraction of their time on the business of governing.

Over time, however, this evolved into a collection of incumbents far more concerned with feathering their own nests and assuring their continuation in office than in the sweaty business of government.

By default, government has become the exclusive preserve of armies of bureaucrats beyond the reach of the ballot box and beyond the reach even of elected officials themselves.

Government, like Nature, abhors a vacuum. The vacuum left by the abdication of Congress has been filled by the bureaucrats, more and more the de facto

rulers of the land of the free.

It is against this dismal background that I fear the bureaucratic control, directly and indirectly, of American medicine — directly through the ever-tightening rules and regulations over federal health care programs; indirectly through the spread of these concepts to the private sectors. Trade follows the flag, the old saying goes, and the flag is now being carried by an elected army of “experts” on the payroll of the people, but not responsible to the people, a disgraceful mockery of the noble concept of representative government.

The modus operandi of Congress for at least the last generation has been to delegate broad, dimly defined powers and rule-making authority to regulatory agencies, commissioners, boards, etc., effectively insulating individual congressmen from public reaction to such rule. Of a piece with this kind of hand-off of authority was the fabled Gramm-Rudman act itself, which made spending cuts across the board mandatory when Congress failed to avoid deficits of threshold magnitude.

Whatever good motives were behind the act, Congress could thus hide behind the mechanical axe swinger and deny, almost plausibly, that any human hand had ever touched appropriations so clobbered. The act created a whole new bureaucracy of its own, one more chunk of representative govern-

ment made unrepresentative.

Power corrupts, Lord Acton said, and absolute power corrupts absolutely. If an all-powerful health care bureaucracy continues to grow in both size and reach, it, not Congress, will be the final arbiter of who, where and when. In due course, as rationing becomes explicit rather than implicit, this bureaucracy will literally have in its power to decide who lives and who dies. If we as a people don't like it, our Congressmen will tell us to tell it to HCFA, and HCFA will tell us these decisions are being made not by a fallible human but by a

“People don’t feel any ownership over the federal government. It isn’t them and it isn’t theirs.” So great has the disaffection become, Garin says, that it is becoming socially acceptable to love your country and hate your government.

supercomputer. Precisely that defense is being offered by Oregon officials in their response to public outcry over Medicaid rationing.

Americans feel so alienated by bureaucratic despotism that they are staying away from the polls in unprecedented numbers, voting with their feet against the vast structure that Congress has built to distance itself from unpleasant reality and troublesome folk.

Geoffrey Garin, a savvy political pollster who has probed American attitudes as deeply as anyone, says: "People don't feel any ownership over the federal government. It isn't them and it isn't theirs." So great has the disaffection become, Garin says, that it is becoming socially acceptable to love your country and hate your government.

Such seeming cognitive dissonances are everywhere. The Markle commission on the Media and the Electorate looked long and hard at such indicators as low voter turnouts and concluded that "a dangerous disconnection is widening between the American electorate and its own political process (presenting) broad, perhaps dangerous implications for democracy in this country."

Another straw in the wind: Republican Congressman Bill Frenzel of Minnesota said when he first came to Congress 19 years ago, "the most powerful forces in my state were the Democrats and the Republicans." Now, he said, they are the "Minnesotans for Life, the AFL-CIO and the National Education

Association. They have legitimate claims on the process, but all of them operate under a much smaller umbrella than the parties."

The tendency by many in Congress and in academe is simply to blame it all on voter apathy, laziness, and ignorance. Some have advanced the notion that those who never bother to vote simply don't care, but surveys have shown that some non-voters tend to be the most caring of all. They simply do not believe that voting for a member of Congress makes any real difference.

And why not? Because, I submit, it has finally dawned on a substantial portion of the population that Congress does not rule; that Congress has given its mandate to a vast and still growing bureaucracy, which never comes up for election. If you cannot vote for or against the real rulers, millions seem to be saying, why bother?

The fatal flaw in this reasoning is that it simply perpetuates in office the very people who have given their jobs to the bureaucrats.

I have faith enough in the people of this country to believe that they will, sooner or later, demand that their country be retrieved from the rabbit warrens of government agencies. But I admit to doubts that this will happen soon enough to prevent considerable wreckage by the bureaucrats now holding hostage the ideals and the self-governing authority of a great people. While some of the wreckage may be reparable, the damage to the fragile institution of medicine could be irreversible. □

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*T. Riley Lumpkin, M.D.
President, MASA*

Bring New Life To MASA

It is an honor and privilege to be your new president of the Medical Association of the State of Alabama. The role of leader has some advantages but it has many more heart-stopping and gut-wrenching responsibilities. And that is where you must understand and appreciate your Medical Association.

Leadership separates one from the common run; not for privilege, pride or self glory, but for service and concern for ALL constituents.

No one physician or small group of physicians can do all the tasks necessary to manage and guide a properly functioning Medical Association. The Association and its leaders (by your vote or your representatives' vote) need the help, the concern, the care and the wise input of every physician in the state; not just those physicians that belong to the Association. And it is a shame not to have every licensed physician join and participate in the affairs of the Association.

Each of us sees every task or problem as our local problem. We respond to local pressures, concerns and attitudes, when in reality we should lift our eyes and see the concerns of our county, our state and our nation. These areas of multifaceted problems need our thoughts and our input on a very regular basis.

When you do consider a problem that may be of a grave nature and you turn to the Association for assistance, remember an answer may or may not be

given to you on each and every letter. Know that your thoughts and worries have been taken into consideration. An answer may be revealed by a personal letter to you or through the action taken by the Association.

The Association and its leaders are similar to football players. Some players complete a pass or good run and show their elation through crowd pressure with many gyrations and dance steps, while the less demonstrative players head back to the huddle with an internal feeling of a job well done. Most players of greater concern fit the last category.

The Medical Association of the State of Alabama was formed by a group of physicians from Selma and Mobile Medical societies in the same year the American Medical Association was created, in 1847. MASA sent ten members to the first meeting of the AMA in 1848. The Medical Association of Alabama was approved 13 Feb. 1850 by the Legislature, or Alabama General Assembly. The Association confirmed in its efforts to improve the quality of medical practice, to establish a hospital for the insane and to develop a medical school in Alabama.

The state hospital for the insane (later known as Bryce Hospital) was established at Tuscaloosa and opened its door in 1861 under the leadership of Dr. Peter Bryce, the first superintendent.

The Medical College of Alabama started in Mobile in 1859 and closed in 1861 due to the War Between

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References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713.
3. *Data on file*, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
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Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

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an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

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Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.


Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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the States, reopened in 1868 and survived until 1920. It was then moved to Tuscaloosa as a two-year Basic Sciences Medical School in the Josiah Nott Building on the University of Alabama campus. In 1944 it moved to Birmingham as a four-year medical school at the Jefferson Hillman Hospital with the first class graduating October 25, 1946. Since then it has grown in size, stature and number of matriculants each year to 165 and reduced several years ago to 150.

The original MASA group struggled financially, but in 1855 ordered 1500 copies of the *Transactions of the Medical Association of the State of Alabama* (better known as the Transactions). This ambitious project brought severe financial strain and bankruptcy to the Association from which it never recovered. This and the onset of the War Between the States caused the Association to lie dormant until 1868, when Dr. Mabry of Selma recommended revival of the Old MASA. Dr. Jerome Cochran of Mobile, elected secretary, rewrote the Association constitution with a strong central organization, a more disciplined body, based on the strong and well run Mobile Society model.

The organization continued to grow. The Association not only met the people's health needs but became a model for similar organizations in other states. The motto developed for MASA was *Nos Etrain Speramus Meliora*: "We also have hope

for better things."

Today your Medical Association provides service, information and support through its three boards. The first is the Board of Censors that runs the association affairs; the second is the Board of Medical Examiners; and the third board is the Committee of Public Health. These three boards are composed of your representatives from each of the seven legislative districts in Alabama, the President of MASA, the Past President and the President-Elect. Also members are the Vice President and five Representatives at Large, with the Speaker and Vice Speaker of the House of Delegates as ex officio members of the Board of Censors.


Information is passed on to you by the *Alabama MD*, sent to you on a weekly basis, as a general news letter that should be read on a regular basis. The Journal of the Medical Association of the State of Alabama, known as *Alabama Medicine*, comes to you every month with scientific, financial and other interesting articles or letters from your President and the Executive Director, Lon Conner, and other physicians throughout the state. On special occasions you will receive a *STAT Rotunda* publication from Dicky Whitaker, your Legislative Department Director, keeping you aware of important legislative actions that need your attention and participation.

Frequent flyers on Continuing Medical Educational adventures, programs, tapes and opportunities are offered to you from Dr. George Oetting, the Director of the Continuing Education Department. Mr. Wendell Morgan of the Legal Department is the General Counsel for the Association and Board of Medical Examiners. Mr. Emmett Wyatt, an Executive Assistant, is in charge of the Administrative Services and Membership Department. The Public Relations Department is directed by Mr. Holley Midgley, who produces the *MASA Report*, a quarterly video newsletter.

Senator Larry Dixon is our Executive Director of the Board of Medical Examiners and William H. "Bill" McDonald is the Director of the Communications Department. Joe Oswalt is the Director of MASA Services. The Committee of Public Health works directly with the State Public Health Officer, Dr. Claude Earl Fox.

The Medical Association of the State of Alabama offers you more than just membership in a fine organization: it offers you the best of organized medicine and we desire your membership and support in all its endeavors. We also welcome the membership of medical students and residents in training.

So, help the Association and yourself - let's bring new life to MASA. Join, support and communicate with your Medical Association of the State of Alabama. □



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In Pride And Anxiety

Kenneth C. Yohn, M.D.

I am very proud of our state licensure and disciplinary boards. My pride in the profession of medicine, I am sure, shows through quite clearly. I am also very proud of the Federation of State Medical Boards for its solid, and, to many, surprising progress made on the single examination pathway to licensure in such a few short years.

From the first FLEX in 1968 to the new FLEX examination in 1985 to the USMLE (United States Medical Licensing Examination) in 1991 – all the while continuing to improve the internationally recognized “BADB” (Board Action Data Bank), the Federation’s publications and projects, and the great assistance it gives to our state boards.

I am proud of the annual meeting and business session of the Federation – from the first independent meeting in New Orleans in 1982 we have made tremendous progress. I am proud of the Federation’s board of directors and the way it has met the challenges and issues – recently having had to take extra time for a search committee to fill the position of executive vice president – the way we dealt with the very serious problem of fraudulent credentials a few years ago – our sojourn into an attempt to evaluation forge in medical education (there is still much more to be done in this area); *The Essentials Of A Modern Medical Practice Act: Elements Of A State Medical Board* (project work panel); the decision on expansion and relocation of our central office and the seemingly biannual requirement to upgrade or replace the extensive and expensive computer systems. Current hot items are the proposal for a central legal clearinghouse

The following comments are excerpted from the address of Kenneth C. Yohn, M.D., Eufaula, newly installed President of the Federation of State Medical Boards at its annual meeting in Birmingham, April 28. Dr. Yohn is a former censor, Chairman of the Board of Censors, and President of MASA. He is also a present member of the Alabama delegation to AMA.

and the possibility of developing a mechanism for evaluating the performance of state medical boards.

But, I am *not* proud of several things currently affecting the profession of medicine. Most of these are external, and they are legion. I won’t attempt to

cover *all* of them but I do want to list a few of them for you so that you may better understand my attitudes and the approaches I take and the approach I often recommend to our Board of Directors and, where appropriate, to your state board.

- We have heard from the Federal Trade Commission regarding restraint of trade. We have recently read in the newspapers’ reports about the *criminal* charges against several MDs in Georgia and other states being dropped. The FTC itself refused to comment publicly, stating that it was not their usual responsibility or procedure to announce when charges were dropped. They had had little difficulty in covering the newspapers with the fact that the charges were brought in the first place.

Our State Medical Association several years ago had to disband its peer review committees which were used to arbitrate payment disputes between third party payors and physicians. Even though this was basically used to insist on a fair range of fee schedules and to avoid the submission and payment of excessive fees, the FTC ruled that even recommending lower fee schedules constituted collusion in fee-setting areas.

We hear there is a problem in fraudulent advertising by physicians. Perhaps there is a problem in physician advertising and perhaps it is a major area of interest, investigation, and prosecution for the FTC. If you

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- Help with staff training.

Perhaps you are planning to start a practice and need help:

- Setting it up,
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- Selecting and training your staff.



Frank Cochran

Perhaps you are considering purchasing an existing practice and need:

- Someone with experience to consult with in the process, or
- Someone to act as your agent.

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believe that, I invite you to pick up the yellow pages of the telephone directory in any city (including this one) and turn to the listings and advertisements listed under "attorneys."

We have heard from bureaucrats that major reform is needed in our medical care payment system. But what we hear makes us wonder if this includes just the payment system or our overall system of medical care. We have been told that it is "folly" to expand the world's most expensive system – not a word about it being the world's *best* system.

We are told it is "tradition" for most people to get their health insurance through the work place. (Tradition obviously develops very rapidly near the Potomac River. A system of health insurance coverage that has been in effect for only two or three decades somehow has now become a "tradition.")

But as to why we can't utilize *this* traditional model to help alleviate the problem of health insurance coverage we are told: "It costs *real* money." Just as if the money the government spends, you having provided it through tax dollars, is not real money.

We are told that our infant mortality rate is "unacceptable." It is too high. But by whose standards is it unacceptable? We are not reminded that is is the lowest ever achieved in the history of this country, nor that it is down to exactly one-half (1/2) of what it was 25 years ago. But – a funny thing happened on our way to bringing OB care to rural and small town areas. The skyrocketing liability insurance rates have forced many, if not most, of our obstetricians to retire from that practice – to the extent that more than 25 out of 67 counties in this state have no obstetrical coverage whatsoever. Very often this extends across two or more contiguous counties. Trial lawyers glibly state that most of those counties never had any OB care in the first place – and they *lie* – and they know it. But then that's their stock in trade.

If you doubt it, go to one of *their* conventions and listen to their seminars on tactics and strategy. Listen to their explanation of the need for an obscene system

that allows them to take up to 50%, or more – or an unlimited amount from the award given to an injured party as a *pre-condition* of even considering to take the case. The poor patient who has had (what the plaintiff lawyer may arbitrarily decide is) a minor injury or some serious mishap which precedent shows our legal system won't award a very high fee, simply gets left out – no where to turn.

And this contingency fee system, allowed only in the U.S., is touted by the lawyers as being "the poor man's key to the courthouse." Who locked the public's courthouse in the first place? And if a "key" is required, who

gave them the authority to be the sole keeper of the key? The plaintiff's attorneys say that we shouldn't tell them what they can charge because they don't tell us what to charge. Really? Just tell that to the physicians and hospitals that deal with MAACs, DRGs, PROs, pre-admission certification, PPO and third-party fees, and mandatory assignment – even that linked to licensure itself.

On the other side of the bar, defense attorneys accept criminal clients and state, quite properly, that their client is entitled to a legal defense. But they then rely on absolute attorney-client privilege in all dealings with their clients. All records

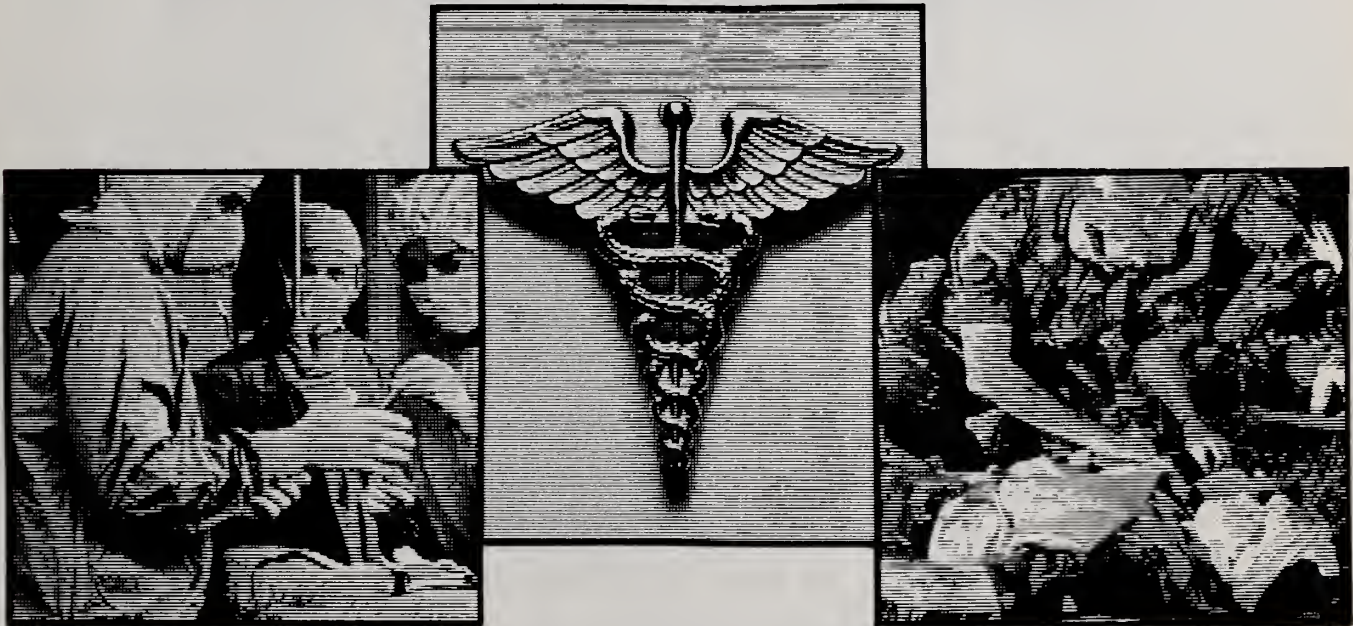
are confidential and secret. Eventually when the case is pleaded in court, those records say only what the attorney and the client have decided they should say.

This legal privilege regarding records is, of course, not extended to physicians and their patients. Even though you as a physician are meeting, interviewing, taking a history from, and trying to treat a fellow human being who is sick or injured – physically or emotionally – asking him or her to be completely truthful and to divulge the most *morally-privileged* facts, fantasies, ideas – even dreams – that record is available to any attorney as soon as the judge says so.

Then that chart or work sheet which becomes a medical record becomes admissible in court, often as a blown-up poster or movie screen sized "visual aid." Whatever the attorney and his client submit on the other side is the final product of his dictation via a

We have heard from bureaucrats that major reform is needed in our system. But what we hear makes us wonder if this includes just the payment system or our overall system of medical care. We have been told that it is "folly" to expand the world's most expensive system – not a word about it being the world's best system.

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legal secretary and a legalese word processor or computer, taken from worksheets and records which remain protected.

But the most glaring example of discrimination against physicians occurred with the regulations passed for the original Medicare act. I remind you that these regulations have never been repealed although HCFA admits that they are violated with regularity.

"Section 160. Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or except as otherwise specifically provided, to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency."

Almost 28 years ago, Dr. Edward Annis sat in a vacant Madison Square Garden and addressed the nation on prime time TV concerning the proposed Medicare act. Among other things in a 30 minute address he said the following:

"This bill would put the government smack into your hospitals! Defining services – setting standards – establishing committees – calling for reports – deciding who gets in and who gets out – what they get and what they don't – even getting into the teaching of medicine – and all the time imposing a federally-administered financial budget on our houses of mercy and healing.

"Ladies and gentlemen, this King-Anderson bill is a *cruel hoax* and a *delusion*! It wastefully covers *millions* who do not need it. It heartlessly *ignores* millions *who do* need coverage. It is *not* true insurance. It will create an enormous and unpredictable burden on *every working taxpayer*."

You decide who has been accurate and truthful over the past 28 years.

Under some circumstances we are told that it is permissible or even necessary to lie to government or Congress, particularly in matters directly affecting

national security. But I do not believe that in any instance is it permissible for our government to lie to the public. But – as Carly Simon sings: "It happens every day."

Two successive administrations in Washington, D.C. now have told us that they are for *free competition* in the marketplace, including the health care marketplace. Tell that to the physicians, hospitals, and other health care providers.

Now President Bush has said that something *must* be done regarding straightening out the medical liability problem. A lone physician-congressman has finally put in a bill to try to help with the massive red tape mess. *It is about time.*

Those of you who are active on your boards of medicine know first hand the intensive detailed physician credentialing and licensure. You know that most boards take *very* seriously their responsibility in dealing with problem physicians and move as expeditiously as the law will allow.

You know that state medical societies and specialty societies insist on and provide quality continuing medical edu-

cation. They give certificates and even many accolades, honors, and awards. Most of these are richly deserved; and little publicized.

Those of you on active hospital medical staffs see the day-to-day function including credentialing, privilege-granting, and ongoing peer review. More importantly you see the dedication that physicians, nurses, and hospitals devote to the care of their patients. And you see the success of that treatment and the occasional tragic, sad, and sobering failures.

I want to tell you that I support physicians and boards of medicine at each of these levels and I am thoroughly committed to their mission and their accomplishments. I am proud to be a part of this profession and this Federation, and I thank you for allowing me to help represent you in the coming year.

And finally, I offer an old Irish prayer which I take very seriously (as I do all prayers): "May the Lord bless those who love us. And those who don't love us, may He turn their hearts so they may learn to love us. And those whose hearts he cannot turn, may He turn their ankles so we may know them by their limping." □

"Ladies and gentlemen, this King-Anderson bill is a cruel hoax and a delusion! It wastefully covers millions who do not need it. It heartlessly ignores millions who do need coverage. It is not true insurance. It will create an enormous and unpredictable burden on every working taxpayer."

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Laparoscopic Cholecystectomy

*L. Lamar Snow, M.D., FACS
L. Steven Weinstein, M.D., FACS
Jeffrey K. Hannon, M.D.*

The first successful operation on the gallbladder was performed by John S. Bobbs of Indiana in 1867.¹ Prior to this, gallbladder sepsis and obstructive cholelithiasis were uniformly fatal. The first cholecystectomy was performed by Karl Langenbuch in 1882.²

The most common incision for operations on the gallbladder was described by Theodor Kocher nearly one hundred years ago. (*Figure 1*). Typically, this incision requires two to five weeks of hospitalization and four to six weeks of recovery. Laparoscopic cholecystectomy is the first major advancement in gallbladder surgery in 100 years. It is routinely performed on an outpatient basis with full recovery in less than one week. The first laparoscopic cholecystectomy in the world was performed by Mouret in 1987. In June, 1988, the first laparoscopic cholecystectomy in the United States and the first in the world using the laser was performed by McKernan and Saye. Less than one year later, one of us (Snow) performed the first procedure in Alabama. This is a report of our first 42 cases.

MATERIALS AND METHODS

Proper instrumentation is the key to a smooth operation. The following is a list of instruments necessary

Laparoscopic cholecystectomy is a new method of removing diseased gallbladders. It has the advantage of being an outpatient procedure with rapid full recovery. Morbidity and complications are decreased, and patient satisfaction has been excellent. This is a report of our first 42 patients selected to undergo this procedure.

to complete the operation. (*Table 1*.) The YAG, Argon or KTP laser or cautery may be used. Cautery, however, is less precise and causes more tissue damage and necrosis resulting in more pain. Cautery may also arc and damage nearby bowel. We have used a YAG in 27 cases, the Argon

in 12 cases, and the cautery in one. We are currently using the YAG with a sculptured polished quartz tip. Cautery is reserved for hemostasis. The instruments listed in *Table 1* are the absolute minimum and the procedure should not be attempted without them. Additional instruments are recommended as part of the complete set (*Table 2*) and back up instruments should be available.

Under general endotracheal anesthesia, a nasogastric tube and a Foley catheter are inserted. The abdomen is completely prepped and draped. The patient is then placed in the Trendelenburg position and a small incision is made in the umbilicus. The midline lower abdominal wall is then grasped and pulled upward. A Verres needle is then filled with normal saline and the valve closed. It is then inserted obliquely into the fascia, aiming just over the sacral promontory. The valve is opened and the needle is further inserted until the liquid runs freely out of the needle. A syringe is then inserted and a small amount of saline injected. If there is no resistance and no return on aspiration, the tip is probably in the free peritoneal space. With

Address reprint request to: L. Lamar Snow, M.D., FACS, Mobile, AL 36607.

TABLE 1
Basic Instrumentation

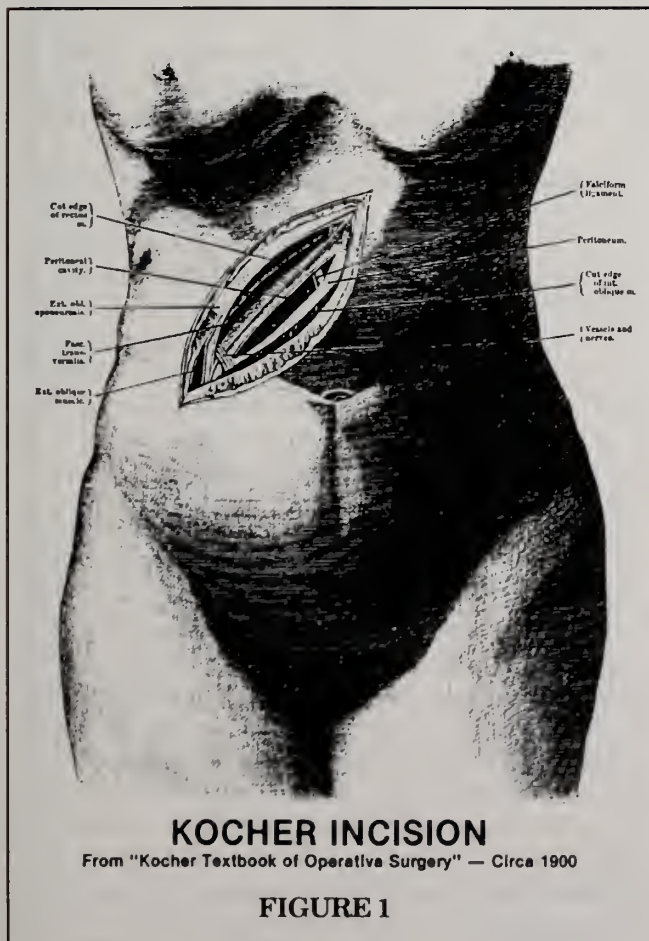
Video laparoscope
High Flow CO₂ insufflator
Verres needle - 1
Laser
Cautery
10 mm trocars - 2
5 mm trocars - 2
10 to 5 mm reducer - 1
Atraumatic graspers - 2
Dissector - 1
Suction irrigation - 1
Clip applier - 1

TABLE 2
Additional Instruments

Hook cautery - 1
Spatula cautery - 1
Bowel forceps - 2
Biopsy forceps
Palpation probe - 1
Aspiration-Injection needle - 1
Spoon forceps - 1
Extraction forceps - 1
Straight scissors - 1
Endoloop applicator - 1
Cholangiogram clamp or laparoscopic
Cholangiocatheter - 1

the insufflator on low flow, approximately 500 cc is insufflated and all four quadrants of the abdomen are percussed and should sound like a ripe watermelon. Continued insufflation is then carried out until approximately 3 liters of carbon dioxide have been instilled, at which time the Verres needle is removed and a 10 mm trocar is inserted in a similar fashion. By depressing the valve, a rush of air confirms the presence of the trocar within the free peritoneal space. A laparoscope is then inserted and visual confirmation is obtained. The

insufflator is then set on high flow automatic at 14 mm of mercury. The peritoneal cavity is then explored and, if no other significant findings are noted, attention is turned to the gallbladder. With the camera attached and while observing the video, a 5 mm skin incision is made in the midclavicular line 2 fingerbreadths below the right costal margin at a point just over the dome of the gallbladder and a 5 mm trocar is inserted. A second 5 mm trocar is then inserted in the right flank lateral to the umbilicus. A fourth puncture is then made in the midline through which a 10 mm trocar is inserted, angulating it laterally and slightly superiorly toward the gallbladder hilum. (*Figure 2*) These are inserted while observing the tips entering the peritoneal cavity. Grasping forceps are then inserted through the 5 mm sheath and the dome of the gallbladder is grasped and rotated superiorly up to the diaphragm toward the right shoulder. Through the lateral port, another grasper is utilized to expose the gallbladder hilum. A reducer is used in the 10 mm midline port to allow for the insertion of a 5 mm dissector which is then utilized to bluntly dissect the peritoneum and fat from the cystic duct and cystic artery. When these are clearly defined, an incision is made in the cystic duct with the microscissors and a cholangiocatheter inserted. A clip may then be placed behind the shoulder of the catheter tip to prevent migration and a cholangiogram is obtained. If the cholangiogram is normal, the cystic duct as well as the cystic artery are double clipped proximally and single clipped distally and divided. It is best to use the laser or cautery in order to preserve the microscissors which are quite delicate and easily dulled. The gallbladder is then removed from the liver with the laser in a retrograde fashion. The liver bed is inspected and any bleeding controlled with the laser or cautery. The operative area is then irrigated clear. The laparoscope is then moved from the umbilical port to the upper midline port to visualize removal of the gallbladder which is grasped by the extractor and removed through the umbilical port. If resistance is met, an inci-



sion is made in the externally exposed neck of the gallbladder and a suction device inserted to remove bile. If a stone is too large to exit the fascial opening, a Kelly or Kocher clamp may be inserted and the stone crushed or the fascial incision enlarged. The skin incisions are then closed with Steri-strips or subcuticular absorbable suture. The fascial incisions are not closed unless they were enlarged. Following anesthetic recovery, all tubes are removed, oral pain medication is given if needed, and the patient is given liquids and ambulated. If tolerated, the patient is discharged with specific instructions including a follow up office visit within seven days.

RESULTS

Of forty-two patients considered candidates for the procedure, we have performed 40 laparoscopic cholecystectomies since March, 1989. All elective patients were admitted the morning of surgery. Surgery lasted an average of two hours and 15 minutes overall with a range of 45 minutes to 4 hours. This was reduced to one hour and 40 minutes in the last 20 patients and one hour and 20 minutes in the last 10 patients performed by the principal author. Cholangiograms are now performed routinely and no common duct stones have been identified to date. Drains were utilized in 3

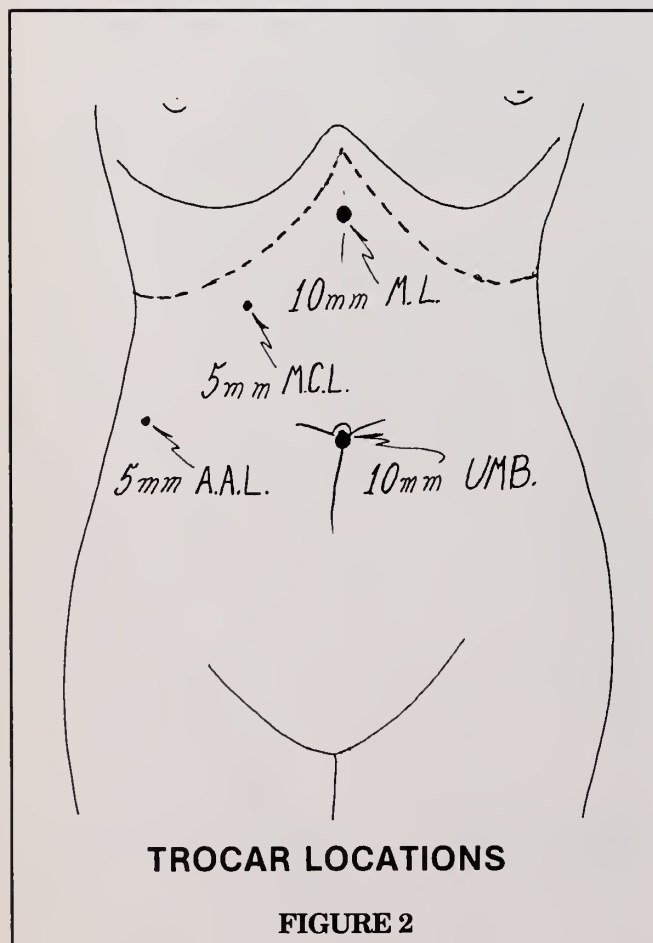
patients with acute infection and positive gram stains. There have been no deaths and no complications. Morbidity has been minimal consisting of mild transient right shoulder pain due to irritation of the diaphragm by carbonic acid formation from the carbon dioxide gas. In all cases this responded to oral pain medication. Transient nausea has occurred in several patients immediately post anesthesia. Average length of stay was 1.7 days (42 hours) for all 40 patients with a range of 6 hours to 5 days, and .8 days (19 hours) for the last 20 patients. The last 8 patients were discharged the day of surgery. There were eight males and thirty-two females. The average age was 40; and the average weight was 145 pounds, with a range of 118 to 306 pounds. Most patients returned to work in one week or less, the majority returning to full activity by the fourth day.

DISCUSSION

Indications for the procedure are symptomatic biliary tract disease and the ability to withstand general anesthesia. Up to 97% of all patients with gallbladder disease may be candidates depending upon the skills and armamentarium of the surgeon. Contraindications may be divided into three categories. (Table 3.)

Absolute preoperative contraindications include septic cholangitis requiring open exploration of the common duct and insertion of a T tube, generalized peritonitis requiring complete abdominal exploration for other pathology, incorrectable bleeding disorders and abdominal distention precluding adequate visualization.

Relative preoperative indications may vary with the skills of the operator and availability of equipment. If the surgeon feels uncomfortable dealing with any of the categories listed under relative contraindications, he should proceed with an open operation without hesitation. If his confidence and skills allow, he should proceed with laparoscopy intending to make a decision after assessing the suspected problem through the laparoscope. We now proceed with laparoscopy in all patients with relative contraindications and have converted only one because of a thickened gallbladder wall. Marked obesity may result in abdominal wall thickness greater than that for which the instruments were designed. We have performed laparoscopy on one male patient with a short stature weighing over 300 pounds with surprisingly good visibility. Several tall patients with long trunks have been difficult because the instruments were almost too short. The dimensional standards for currently available laparoscopic equipment were designed for use in visualizing and working in the female pelvis and should be four to six inches longer for general laparoscopic work. The most difficult procedure performed was in a patient with long standing chronic cholecystitis in a subacute phase with a



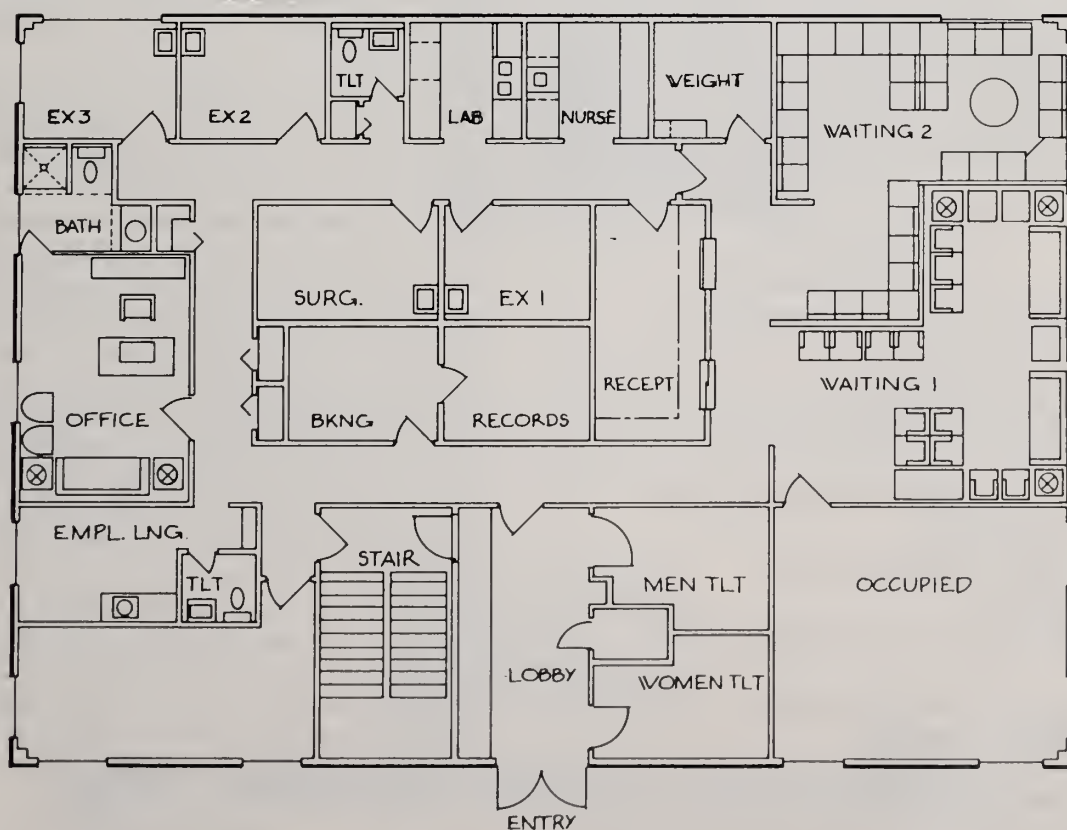
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markedly thickened wall. We now perform laparoscopy and, if several attempts at grasping and manipulating the gallbladder are unsuccessful, proceed with a muscle splitting subcostal incision. Patients with jaundice or a history of jaundice are not excluded. Patients with known common duct stones are managed with endoscopic sphincterotomy, then undergo laparoscopic cholecystectomy. Patients with a history of jaundice or a falling bilirubin with normal hepatocellular function undergo the procedure with a qualified ERCP sphincterotomy physician on standby. If a common duct stone is found on cholangiogram, removal is initially attempted through the laparoscopic by manipulation with a 3 mm ureteroscope through the cystic duct. If unsuccessful by this method, an endoscopic sphincterotomy may be performed while in surgery or, if the stone is small, this may be delayed for twenty-four to forty-eight hours to allow for spontaneous passage. If the stone does not pass, sphincterotomy is performed within forty-eight hours.

Multiple previous abdominal operations with anticipated adhesions to the anterior peritoneal surface should alert the surgeon to possible bowel injury during insufflation. The Verres insufflation needle should be directed inferolaterally away from the suspected adhesions and great care exercised to be sure the needle is intraperitoneal before insufflation. If there is uncertainty at the umbilical location, the abdomen can be insufflated through a quadrant where adhesions are not suspected. The right upper quadrant is usually free of adhesions. Once insufflated, adhesions can be taken down through the operating laparoscope until free access to the abdomen is obtained for insertion of the

trocars in the normal position. If the free peritoneal space cannot be found after a reasonable attempt, a standard incision should be made.

Intraoperative findings resulted in conversion to an open procedure in two of the forty-two patients in this series, one because of an intrahepatic gallbladder and the other because of a markedly thickened wall which could not be grasped. Conversion to an open operation is not a complication but part of the operative technique and represents good surgical judgment. The patient should be thoroughly versed on the potential for conversion to an open operation and the surgeon should not hesitate to make the conversion when needed.

CONCLUSIONS

Video laparoscopy is a safe revolutionary approach to removal of the gallbladder. It is clearly superior to open cholecystectomy. Advantages include better visibility and precision, less morbidity and fewer complications. This along with reductions in length of hospital stay and time lost from work have tremendous socioeconomic benefits. At 600,000 cholecystectomies per year, saving four 40-hour weeks per patient, 96 million man hours would be gained. Over \$1 billion per year would be saved by reducing the average hospital stay from an average of 3.2 days to less than 1 day. Follow up office visits are reduced. Most patients are seen only once at approximately one week post surgery and discharged if well.

This procedure requires new skills unfamiliar to the majority of practicing surgeons. It is clear from the data that there is a long learning curve. As we gained experience with each procedure the average operating time and hospital stay were shortened and patient selection broadened. The average surgeon will not become comfortable until he has performed 15 to 25 procedures and will not become expert until he has performed more than 30. This paper is not intended to supplant time honored teaching methods. It is recommended that each surgeon obtain adequate training before attempting this new procedure. This should include all of the classic steps as in residency training including literature search, didactic lectures, observation, hands on assistance and, finally, as the primary surgeon with an experienced proctor assistant. Uniform credentialing recommendations have not been publicly addressed by any surgical organization. Laparoscopic cholecystectomy, however, as well as other laparoscopic general surgical procedures, are true advancements in surgery and will, with time, become the standard of care. □

TABLE 3
Contraindications

- A. Absolute preoperative contraindications
 - 1. Septic cholangitis
 - 2. Generalized peritonitis
 - 3. Incorrectable bleeding disorders
 - 4. Abdominal distention
- B. Relative preoperative contraindications
 - 1. Marked obesity
 - 2. Thickened gallbladder wall
 - 3. Jaundice
 - 4. Multiple previous abdominal procedures
- C. Intraoperative contraindications
 - 1. Inability to insufflate
 - 2. Abnormal anatomy
 - 3. Uncontrolled bleeding or shock
 - 4. Known or suspected injury to bowel or hepatobiliary duct
 - 5. Inability to grasp the gallbladder wall

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2. Langenbuch, K.: Removal of the Gallbladder with Chronic Cholecystitis. Berl. Klin Wochenschr, 1882;48:725.

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Lyme Disease In Alabama

R. Ross McBryde, M.D.

Lyme Disease is a tick-born spirochetosis that has only recently been identified in the United States. This disease has been described in at least 33 states and 20 countries and on 6 continents^{1, 5}, however, in the state of Alabama it has not usually been considered in the differential diagnosis of the many symptom complexes that it may produce, even though it probably is more common than thought.

The pathognomic skin lesion, Erythema Chronica Migrans, was first described in the European literature in 1909. Neurologic involvement was first noted in the early 1920s, and at that time it was not yet associated with arthritis.^{2, 7} The recognition of Lyme Disease in the United States began in 1972 when a geographic cluster of arthritis in children occurred in the area of Lyme, Connecticut.^{8, 13} Most of the current knowledge of the disease was initially described through the work of investigators at the Yale School of Medicine.^{1, 7, 8}

Lyme Disease is caused by the spirochete *Borrelia burgdorferi*. It is transmitted by the deer tick.^{14, 15} This disease has been found to occur most commonly in three geographical areas of the United States^{1, 5}: the northeast, more in the coastal areas, from Maryland to northern Massachusetts,² the upper midwest, in Wisconsin and Minnesota,³ and the far west, in California and Oregon. These areas, as would be expected, correspond to the distribution of the predominant tick vectors of the disease, *Ixodes dammini* in the east and *Ixodes pacificus* in the far west.⁹ It is becoming better recog-

nized in other areas of the United States, especially in the lower midwest, eastern Texas and the southeast. Other ticks, *Ixodes scapularis* and *Amblyomma americanum*, are known to transmit *Borrelia burgdorferi* though less frequently than *ixodes dammini*, and account for the spread of the disease in the southeast.²¹ The first documented case of human Lyme disease in Alabama was in 1986, at the Alabama Agricultural Experimental Station. A Lee county woman had been bitten by ticks on a family camping trip to the Choccolocca Wildlife Management Area in northeastern Alabama. Subsequently, a collection of 148 specimens of two tick species, including both nymphs and adults, was obtained in this area. The majority (88%) were the lone star tick (*Amblyomma americanum*). The remainder was the dog tick (*Dermacentor variabilis*). None of these specimens, however, were found at the time to be infected with the agent of Lyme disease. The most common tick infesting white tail deer in Alabama, however, is the black legged tick (*Ixodes scapularis*) and probably is the more important. This species is closely related to *I. dammini*. Like *I. dammini*, its larvae and nymphs parasitize small mammals, whereas the adults are found primarily on wild deer. In laboratory tests at University of Alabama Birmingham, black legged ticks collected in Alabama were shown to be capable of being infected by *Borrelia burgdorferi* and transmitting this bacteria to hamsters.^{22, 23}

Lyme disease has different clinical stages with remissions and exacerbations. The stages may

overlap or occur separately. The illness usually begins in the summer with a typical skin lesion, erythema chronicum migrans, that may be accompanied by fever, headache, stiff neck fatigue malaise, myalgias, or arthralgias. Weeks to months later, stage 2 may appear consisting of neurologic or cardiac abnormalities, and weeks to years later, stage 3 consisting of arthritis.^{3,17} In stage 1, four to twenty days after a tick bite, about 80 to 90 percent of patients will develop a characteristic rash, erythema migrans.¹ This rash begins as a small erythematous macular or papulae, which enlarges to form an annular lesion which is usually found at the site of the tick bite. Accompanying the rash are flu-like symptoms including malaise, fever, headache, chills, and regional adenopathy.¹⁶ About half the patients develop multiple annular skin lesions. Stage 1 usually lasts three weeks and resolves spontaneously, however, at this time the symptom complex may be rapidly changing and developing. If antibiotic therapy is started early, these initial symptoms resolve faster.¹ Weeks to months later stage 2 occurs, including neurologic, cardiac, and ophthalmologic complications. The neurologic complications include meningitis with headache, nausea, vomiting, stiff

neck, photophobia, encephalitis with somnolence, depression and other behavioral changes. Additional neurological manifestations include cranial neuritis usually affecting cranial nerve VII (Bell's Palsy). Also cranial nerves III, IV, and VI have been reported to be affected. In addition, peripheral neuropathies include mononeuritis multiplex, myelitis, and intermittent paresthesia.^{1, 11, 12} These neurologic findings occur in 10 to 15 percent of patients. Cardiac complications occur in approximately 5 to 10 percent of untreated patients, the most common findings include first degree atri-

oventricular block, though complete AV block (3rd degree) may occur, and can be associated with syncope requiring insertion of a temporary pacemaker.¹⁸ Rarely, diffuse myopericardial disease with impaired left ventricular function may occur. Involvement of heart valves has been been reported. These cardiac lesions usually resolve within days or weeks.¹ Stage 3 occurs from weeks to years after the initial infection. About 60 percent of untreated patients develop arthritis. This arthritis is usually monarticular or an asymmetric oligoarticular arthritis affecting primarily the large joints, especially the knee.

The arthritis is rarely symmetric or migratory.^{13, 17} A chronic deforming arthritis will develop in approximately 10 percent of these patients.¹ The histology of the synovial tissue in these patients resembles that seen in rheumatoid arthritis.

The majority of physicians in Alabama would not usually consider Lyme Disease a very likely possibility in the differential diagnosis of acute or chronic joint disease, therefore, the following case should be of some interest.

The patient, a 24-year-old college student, was seen June 19, 1989, complaining of pain in his left knee for approximately one month. This began as a mild soreness progressing in 10 days to

being quite tender then improving to some extent. He recalled that after riding his bicycle in the woods, and sitting in the grass, near Mobile, and in the Tuskegee National Forest, that he developed a rash on his left thigh. This was about 3 cm in diameter and had a clear center. It persisted for about 2 weeks before fading. On May 13 he developed sharp cramping abdominal pains just above the umbilicus. These pains were recurrent and at times severe, finally culminating in a trip to the emergency room where there was noted no abdominal tenderness and blood counts and flat and upright

The treatment of Lyme Disease depends on eradicating the infecting organism from the human host. Usually early disease is more responsive to antibiotic therapy than late disease. If instituted in the first 1 to 2 weeks of illness, appropriate antibiotics will shorten the duration of erythema migrans and prevent later sequelae in most patients.

films on the abdomen were non-revealing. On June 9th he developed a pleuritic type pain bilaterally in the lower posterior thorax which gradually subsided in 2 or 3 days. During this time there was no known fever, night sweats, or weight loss. There was at times some dysuria but more after voiding.

Physical examination revealed very little. There was no fever. Vital signs were all normal. There was no adenopathy. The only abnormality was in the left knee where there was some slight thickening in the infrapatellar tendon. There was no erythema or tenderness. Laboratory data revealed a white blood count of 5300 with segs. 68%, lymphs 29%, eos 3%, Hemoglobin 15.6 gm., hematocrit 45%, sedimentation rate, 3 mm hr., urinalysis specific gravity 1.018, albumin negative, glucose negative microscopic, an occasional epithelial cell. Blood chemistries revealed calcium 10.5 mg. dl., glucose 97 mg. dl., triglycerides 60 mg. dl., uric acid 5.4 mg. dl., cholesterol 190 mg. dl., bun 13 mg. dl., creatinine 1.2 mg. dl., sodium 137.8 mM L, potassium 4.4 mM L, albumin 5.0 g dl., total protein 6.8 g dl., A/G ratio 2.8, SGPT 11 UL, SGOT 13 U L, alkaline phosphatase 40 U L, LDH 84 U L, total acid phosphatase 2.8 U L I, phosphorous 3.89 mg. dl., total bilirubin 1.4 mg. dl., Lyme Disease Antibodies was positive 1:512 (normal <1:128). This assay measured both IGG and IGM antibodies to Lyme Disease. A chest x-ray revealed the lung fields to be clear and the heart was normal size and contour. An ecg was within normal limits. A 2D echocardiogram revealed only a minimal amount of pericardial fluid with an ejection fraction of 58%. On June 21 the patient was begun on intravenous Rocephin (ceftriaxone) 2 grams in 50 cc's of .09% sodium chloride twice daily. Within 48 hours the discomfort in the left knee was practically gone, only to recur mildly for a few days when the patient became more physically active. There was within a few days a return to a feeling of well being, that had been absent for several weeks. Two months later, a repeat Lyme disease antibody titer was <1:128.) A repeat CBC, Urinalysis, sedimentation rate, and chemistry profile were all normal and he remained clinically asymptomatic until Jan. 7, 1990 when he again noted soreness in his left knee, which was not swollen. This was followed by headache, that was bifrontal and temporal, lightheaded sensations, nausea, temporomandibular soreness, then soreness in both knees. There was no recorded fever. A further evaluation at this time revealed no abnormal findings. Repeat laboratory tests including cbc, sed. rate, chemistry profile, and VDRL were not abnormal. A repeat ELISA was <1:128. A western blot test was negative. Despite all of the negative findings, however,

the diagnosis of Lyme Disease must rely heavily on the evaluation of the patient's history and symptoms.²⁶ The patient was thus begun on Cefixime (Suprax) 800 mgm. orally, once daily for a total of 8 weeks. He ingested 6 to 8 ounces of yogurt daily during this period and the treatment was well tolerated with minimum gastrointestinal side effects. Two to three weeks later there was an exacerbation of knee pain for about three days and then improvement though some soreness in the left knee was present in the 8th week.

The most reliable method of diagnosing a disease process is either demonstrating the microorganism in tissue or culturing it from patient specimens. In studies reported to date in Lyme Disease, these techniques have not been practical. *B.burgdorferi* grows well in vitro, but it has been recovered infrequently from human specimens including skin, blood, cerebrospinal fluid, and synovial fluid.¹⁰ Visualization and identification of tissue bound *B.burgdorferi* are not commonplace because of the paucity of bacteria and the requirements of a knowledgeable pathologist and special laboratory techniques.² A test for detection of a specific antibody to *B. burgdorferi* is currently available and is the most useful laboratory method for diagnosing Lyme disease, however, it is not infallible.²

The serologic diagnosis of many infectious diseases is done by the testing of acute and convalescent specimens. In Lyme disease, however, testing of a single specimen usually is sufficient. The diagnosis of stage 1 Lyme disease is usually a clinical determination and a serologic test is, at best, confirmatory. In this stage a negative serologic test does not exclude the disease because sensitivity is approximately 40 to 60% during the early stages when erythema migrans and minor constitutional symptoms predominate.² Those patients with clinical Lyme disease should receive prompt antibiotic therapy without waiting for laboratory confirmation, since a negative test in this early phase would be meaningless. It has been noted that the early administration of antibiotics is likely to abrogate the antibody response. Practically all patients with complications of stage 2 or stage 3 Lyme disease will have a positive serologic test on the first specimen submitted.^{10, 24}

The serologic tests most commonly used are the immunofluorescence assay and the enzyme linked immunosorbent assay (ELISA). The ELISA is currently preferred as the procedure with better sensitivity and specifically for all stages of Lyme disease, however, in the early weeks of infection it lacks the desired level of sensitivity.²⁴ The cause of the decreased sensitivity is unclear. Most likely, low levels of specific anti *B.burgdorferi* antibody

overlap the background values of antispirochetal or cross-relating antibodies found in normal persons.^{10, 25}

The treatment of Lyme Disease depends on eradicating the infecting organism from the human host. Usually early disease is more responsive to antibiotic therapy than late disease. If instituted in the first 1 to 2 weeks of illness, appropriate antibiotics will shorten the duration of erythema migrans and prevent later sequelae in most patients.

The treatment regimens currently recommended may well prove to be inadequate in many cases. Some of the current recommendations are: Oral tetracycline HCL 250 mg qid or doxycycline 100 mg bid administered for 10 to 21 days depending on the response are considered the methods of choice in children over the age of 9 and adults, excluding pregnant or lactating women. Penicillin V, 250-500 mg qid or Amoxicillin 250 mg tid, given for 10 to 21 days are also effective choices and are preferred for early disease in pregnant or lactating women. When Lyme disease has progressed to the disseminated infection found in the late stages of the disease, successful treatment becomes more difficult. In one study only 55 percent of patients with Lyme arthritis responded completely to conventional antibiotic regimens.⁴ Late stages of disease require more intensive antibiotic therapy. Carditis is usually treated with intravenous penicillin 10 million units daily for 10 days. Intravenous ceftriaxone sodium, 2 gm daily, is an alternative treatment.

Patients with meningitis or meningoencephalitis with or without cranial or peripheral neuropathy, respond to intravenous penicillin, 20 million units daily for 10 to 14 days. The latter may be more effective therapy for neurologic disease. Later neurologic manifestations, including neuropsychiatric syndromes, are less responsive to antibiotics, but should be treated aggressively with either intravenous penicillin or ceftriaxone. It is becoming apparent that three to four weeks of antibiotic therapy is more appropriate in most cases of Lyme disease and that there is a high rate of relapse in patients who are symptomatic at the cessation of therapy. It is possible, however, that some of the symptoms, especially those affecting the musculoskeletal system are caused by immune responses against B.burgdorferi antigens;²⁰ if this is true, no antimicrobial therapy will be able to abolish all symptoms.²⁶ Optimal therapy for such syndromes is unclear at this time.²¹ In the case reported in this article, the recommended dose of 2 weeks of i.v. Ceftriaxone was inadequate. It would seem that 3 to 4 weeks would have been a more appropriate length of therapy.

COMMENTS

The recognition of Lyme disease in Alabama requires a new sense of awareness in the differential diagnosis of many clinical presentations. This involves not only the disciplines of primary care, but cardiology, neurology, rheumatology, orthopedics, ophthalmology, infectious disease or dermatology. Any of these practitioners may be initially consulted because of the protean manifestations of Lyme disease. The onset of heart block in an otherwise healthy individual, Bell's Palsy, particularly when bilateral, meningoencephalitis, acute arthralgias in patients who have a likelihood of tick exposure should raise a high index of suspicion, because it is likely that there is more Lyme disease in Alabama than has been to date detected. There remains a need for a more specific and sensitive test to detect active B.burgdorferi infections. These tests are being developed at the present time and no doubt will be available on the local level in the near future. □

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Obstructive Sleep Apnea

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Obstructive Sleep Apnea (OSA) is a major problem in the United States. Snoring has been reported to occur in nearly 21 million individuals.¹ It has been estimated that 7 million adults have obstructive sleep apnea.² The National Center for Health Statistics in Hyattsville, Maryland, estimates that 5,000 people underwent Uvulopalatopharyngoplasty (UPPP) for OSA between 1983 and 1984.³

Recognition of sleep disorders probably dates back to the time of Hippocrates when he questioned the mechanism of infant death during sleep.⁴ The symptoms of obstructive sleep apnea were recognized and described in the 1800's. In 1837, the Posthumous Papers of the Pickwick Club of Charles Dickens described a fat boy named Joe who had persistent somnolence. Caton and Lamacq both felt that narcoleptics may suffer from obstructive airways during sleep that produced periodic suffocation. In 1918, Sir William Osler coined the phrase "Pickwickian Syndrome". The etiology and location of the abnormality was demonstrated by Schwartz and Escande in 1967 using cinematography demonstrating pharyngeal collapse in the obstructive apnea of a Pickwickian.⁵

In 1964, Ikematsu described snorers to have narrow pharyngeal dimensions and larger soft palates and uvulas.⁶ He also described curing patients of snoring with resection of the uvula.

Fujita, who is considered the father of the UPPP, reported his results on 12 patients, 8 of which did well and 4 of which did not and asked a rhetorical question "why"?⁷ Also Blair Simmons expressed concern in his report of 155 patients who had a UPPP of not being able to predict which patients would do well.⁸

OSA patients present with the primary symptoms of excessive daytime somnolence (EDS) and sonorous snoring. EDS is defined as falling asleep in situations that are entirely inappropriate.⁹ It is not a description of lethargy or fatigue. Often a patient's bed partner will describe restless sleep and marked snoring with periods of cessation in breathing. Morning headaches and dry mouth are often present in patients with OSA.

Depression and irritability are also associated with OSA.¹⁰

OSA patients are usually middle-aged men who are obese and often have large tonsils, enlarged soft palates and uvulas. Short thick necks, retrusive mandibles and narrow maxillas are often found on physical examination. Hypertension is common in patients with OSA.¹¹ In fact, 30% of a group of 46 middle-aged males with essential hypertension were found to have significant sleep apnea.¹² Due to the hypoxemia in OSA, cardiac arrhythmias are often found. Right heart failure and pulmonary hypertension may be clinically significant if daytime ventilatory disturbances are also present.¹³

The primary laboratory tool used in the diagnosis of OSA is polysomnography. Polysomnography incorporates the simultaneous recordings of an EEG, EKG, electroculography, nasal air flow, arterial blood oxygenation and chest movements.

"Polysomnography is a useful adjunct to the clinician because it provides objective information to be integrated into the overall clinical picture in the evaluation of the patient's complaint."⁹ It is felt that a sleep study should be obtained in adult patients to confirm OSA prior to surgical or medical intervention.

PATIENTS AND METHODS

The charts of 133 patients who were operated upon between 1984 and 1987 by the authors, Turner and Stevenson, at Baptist Medical Center-Montclair were reviewed. All patients were studied pre-operatively in the Sleep Disorders Clinic of Alabama at Baptist Medical Center-Montclair in Birmingham, Alabama, obtaining polysomnography under the direction of Dr. Vernon Pegram, Ph.D. and Joe Hernandez, R.Psg.T. Also all patients were evaluated prior to the sleep study by Drs. Sutton and Doekel. The statistical analysis was provided by Dr. Seng-Jaw Soong, Professor of

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the Department of Biostatistics and Biomathematics of the University of Alabama in Birmingham, on a group of 84 patients who had had pre- and post-operative polysomnography where complete data was available for analysis.

RESULTS

Demographic evaluation reveals a male preponderance with a median age of 50. The median weight and height were 238 lbs. and 69 inches respectively. Of the group of patients for whom pre- and post-operative apnea indexes (no. of apneas/hr) were available, 72.63% were improved, 14.74% were not improved and 12.63% were worse.

The difference between the pre- and post-operative apnea index and the lowest desaturation were found to be highly significant by the "paired t-test" to a P-value of less than 0.00001. Fifty-three percent of the 84 patients had a 51% or greater reduction in their apnea index following surgery. When results were evaluated relative to age, there was a marked reduction in the number of patients improved as their age increased. Those patients who underwent UPPP with tonsillectomy and any other associated procedure, had the best results in comparison to those undergoing UPPP with other procedures but without tonsillectomy. In evaluating age relative to the procedures done, there continued to be the trend of poor results in the older patient population, whether a UPPP with tonsillectomy, with or without a nasal procedure, were done.

DISCUSSION

Obstructive apnea is a disorder of closure of the upper airway space during sleep. Many factors contribute to the closure of the airway. Obstruction can occur at the lateral pharyngeal walls or from the tongue against the soft palate or concentric collapse of the hypopharynx.¹³

Also conditions that produce increased nasal resistance predisposes a person to OSA.¹⁴ Obesity plays a major role in producing OSA. Pharyngeal cross-sectional area may be reduced by reduction in the functional residual capacity which is typical in the obese patient.¹⁵

Our statistical review of 84 patients compares favorably with other centers. Our overall success rate is 72.63% improved. Fifty-three percent of the patients had a reduction of 51% or greater in their apnea index which is similar to that reported by Simmons in his review of 155 patients who underwent UPPP. Nine patients in our series of 133 required a tracheotomy either before or at the time of UPPP and all were decanulated.

Our analysis would indicate that the pharynx is the primary site of obstruction. When UPPP was performed with tonsillectomy with or without a nasal pro-

cedure, the amount of improvement in the post-operative apnea index was greatly enhanced. This is corroborated by the studies of Hill and Rajewski who demonstrated by fiberoptic and fluoroscopic techniques respectively that the pharynx is the primary site of obstruction.^{16,17}

Criteria for selecting patients for UPPP in the management of OSA remain unclear and the prediction of a positive result remains an enigma.¹⁸ In our study, it was demonstrated that as age increased, there was a marked reduction in the improvement of the post-operative apnea index. This finding was significant to the P-value of less than 0.05. The age dependency may be related to prolonged mechanical injury due to snoring. Bradley stated, "It may well be that over a period of years, mechanical injury due to snoring (vibration of pharyngeal soft tissue) results in swelling of the soft tissue, a progressive increase in pharyngeal compliance and eventual obstructive apneas."¹³ These factors may give credence to early surgical correction of snoring and obstructive sleep apnea in the younger patients.

Our brief study demonstrated that removal of tonsils with a UPPP seem to produce improved results. Also increasing age markedly reduces the success rate of UPPP and UPPP in conjunction with other airway procedures. Further basic and clinical research will be needed in order to improve patient selection and surgical management of the patient with obstructive apnea. □

FOOTNOTES

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*Mrs. Charles Patterson
A-MASA, President*

Prevention Objectives

A uxiliaries and friends, thank you for placing your confidence and trust in me as president of our Auxiliary for 1990. As President-Elect, I have had the opportunity to review the goals, problems, and accomplishments of our auxiliary, and I am proud of what our organization has achieved. I have enjoyed my association and membership with the auxiliary and I look forward to working with each of you as we work for the best in health care for our communities. As in years past, we will continue to support the Medical Association of the State of Alabama; we stand ready and willing to implement programs and projects as we are needed. We welcome the opportunity to work in coalition with the Medical Association throughout the year ahead. The hallmark of our organization has been the achievement of preventive medicine through the implementation of projects for public medical awareness and education. Recent projects have included the prevention of child abuse, teen pregnancy, AIDS, substance abuse, as well as increased participation in programs for the elderly and diet modification. Through the Shape Up For Life Program, auxiliaries continue to help educate their communities on good health habits. All of these projects have been organized and tailored to the individual auxiliary's needs with the national and state organization providing speakers and material support. This year we expect to concentrate on adolescent health, AIDS education, and early detection of breast cancer. We will continue to reach out to others who are in need of medical supplies and equipment through the Metal Implant Program and our International Health Project. Lynda Wool, our

chairman of health projects, will coordinate these efforts from the state level.

The second goal of the auxiliary has been the support of medical education through the American Medical Association Education and Research Foundation. In 1989, auxiliaries across the nation raised over 1.8 million dollars to help finance medical education. The per capita contribution of our state membership through sharing cards, auctions, and other fund raisers over the years has been commendable. The importance of this accomplishment is enhanced in recent years when the cost of education has risen much faster than even the widely publicized figures for medical care. In 1990, I expect to continue this philanthropic effort by continuing and building upon the successful ideas of the past. Donna Gosney, our AMA-ERF chairman, will be coordinating our energies to this goal.

The third and most complex of our auxiliary's goals has been the promotion of political education and awareness. We are not a political action committee, and we do not endorse specific political candidates. However, we and our spouses have a moral obligation to actively pursue political awareness and education on any issue which threatens to compromise the delivery of health care to the citizens of our state. The very license to practice medicine, which our spouses often take for granted, is a political act of the state legislature generated by the political education and awareness effort of the first formally trained physicians in this state. The same can be said for the laws governing prescription drugs. Therefore, for us to withhold our money and time from political

education and awareness is to abandon our heritage. In 1990 both the Governor and the Legislature will be up for re-election. Their receptiveness to political education and awareness will never be greater. Our political system is really very simple. It is a critical part of our lives, and like our other projects, it responds to time, work, and money.

Over the last decade we have experienced a steady growth in our state auxiliary membership. Currently we have over 2,000 members in our state organization. Under the leadership of our membership chairman, Margaret Mitchell, our membership team will work to welcome and recruit every physician's spouse into the auxiliary. We hope increasing our membership will bring new talent, ideas, and leadership into the organization. It will make us a stronger support system for the Medical Association of the State of Alabama. We will encourage the potential members who have just moved into the community and those who have fallen by the wayside to become involved. Once in the auxiliary they will not only find a special fellowship, but a hard working, talented group of individuals devoting their energies to impacting the health care needs of their communities.

Auxilians, our goals in 1990 are clear and the opportunities for service in our communities are many. We have the time, the energy, and the means to accomplish much. We must make the commitment to MAKE A DIFFERENCE. □

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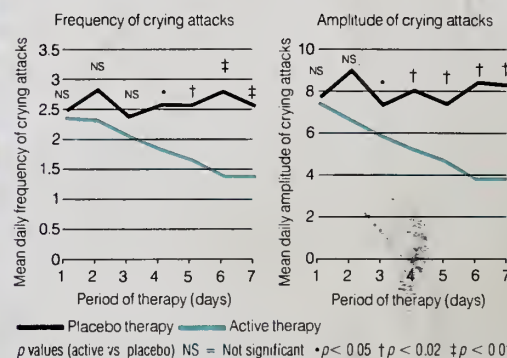
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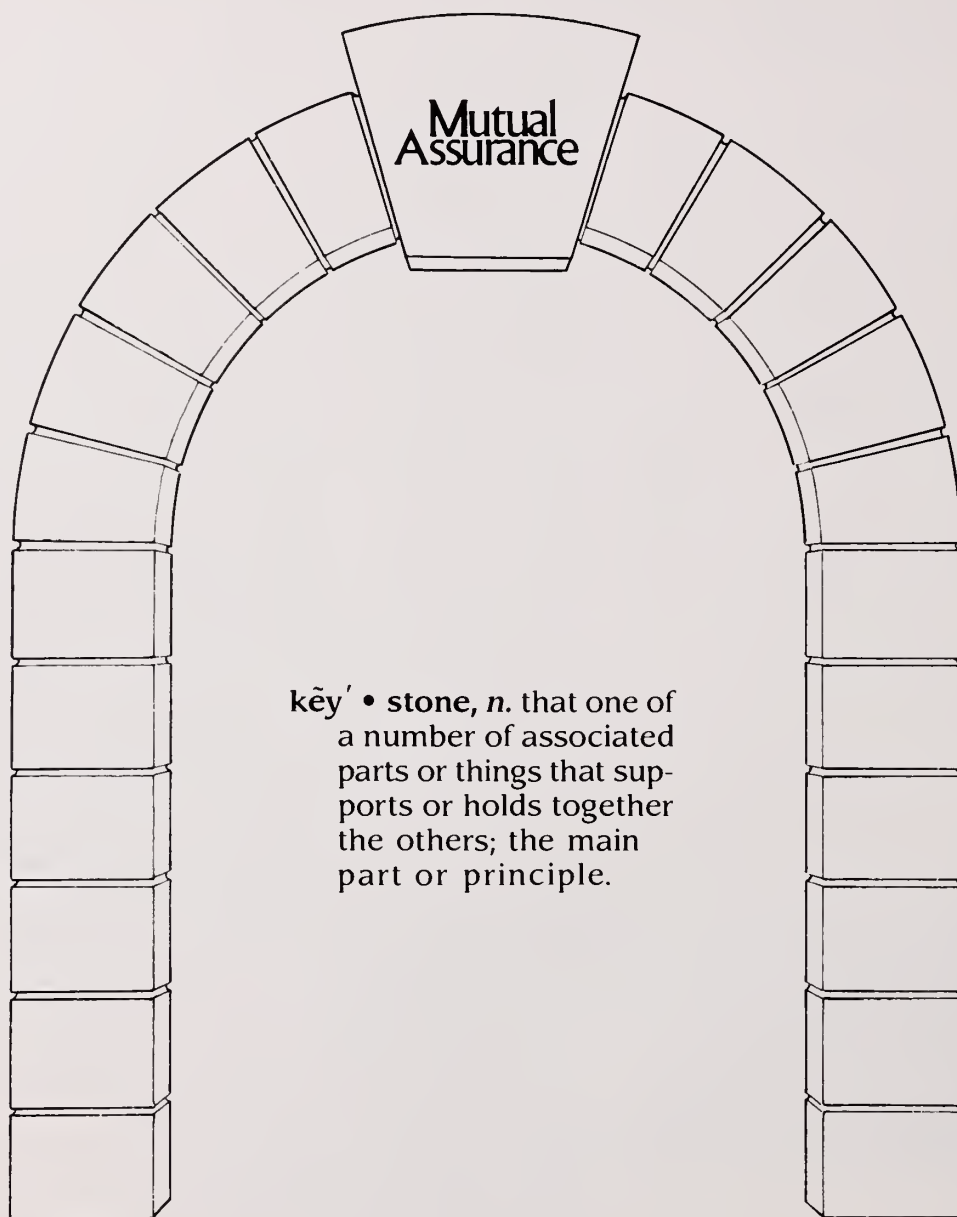
JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

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Medicare Physicians Reimbursement

see page 11

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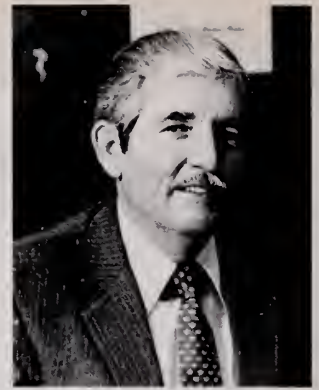
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S. Lon Conner
Executive Director, MASA

The Nature Of Things

A year or so ago, an editorial in the *Journal* of the Southern Medical Association commented rather mordantly that who gets transplants is increasingly determined by who knows the anchor-man on the nightly news.

That phenomenon has been witnessed here in Alabama time and again: only those few whose friends organize a highly emotional and heavily publicized fund-raising campaign can raise huge sums often needed by those without means or insurance.

Public generosity then offers these lucky few the chance for a miracle. At the same time, however, many other equally deserving potential recipients die quietly—unwept, unhonored and unsung.

Obviously, local TV cannot devote itself entirely to such heart-rending campaigns. Thus the station rations the appeals to those whose cases are particularly dramatic—the pretty little girl or the winsome little boy and their poor but proud parents. The more photogenic they all are, the better. The tube is, after all, an entertainment medium primarily interested in spectacle.

But this too is another example of rationing medicine, neither more nor less chaotic than the others as the nation gropes toward the realization that in the allocation of finite resources everyone may be theoretically equal but some will always be more equal than others.

About a year ago, the American Cancer Society

reported on its survey of the tens of thousands of Americans dying of cancer, alone and unattended in their pain and despair, covered neither by private insurance nor any government program. The few who read the report said, too bad, and forgot about these suffering unknowns. They have no lobby, no organization, no one to approach the anchorman in their behalf. For the most part, they don't vote; consequently, they have little standing in Congress, where the worth of causes is sometimes measured by the size of the affected bloc.

As this was being written, scientists, physicians and public officials were disgusted, but hardly surprised, by the reception given HHS Secretary Louis W. Sullivan in June as he attempted to address the Sixth Annual Conference on AIDS in San Francisco. Militant homosexuals blew whistles and air horns, threw wads of paper and screamed insults at the Secretary, denying him the right to be heard.

Dr. Sullivan was being vilified, of course, as the symbol of an "uncaring" government, which has not provided everything the gay-lesbian pressure group wants. They stridently insist that the United States owes them everything to make the world safe for their lifestyle. They will be satisfied, it appears, with nothing less than all the health care dollar.

As this was written, the Senate had voted \$2.9 billion, the House \$4 billion over five years for

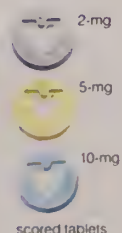


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The Stylebook/Editorial Manual, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

Length of Articles: Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

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treating only AIDS.

When one Senator introduced an amendment to permit rural districts with few AIDS cases to spend some of the money on other diseases, the amendment was defeated 2 to 1. Why? The militant AIDS lobby has intimidated an already timid Congress into bestowing unprecedented funding on AIDS, but nobody among those suffering silently from other diseases had taken to the streets outside the National Institutes of Health and before Congress, as the AIDS agitators had done in what was described as the angriest demonstration in a long time.

If you don't know the anchorman, and can't muster a mob to march on Washington, forget it. That seems to be the message. Congress and elected officials react only to intimidation of the multitude.

In an essay in *Time* magazine (June 25, page 80) Charles Krauthammer explored this grotesque distortion of national priorities brilliantly and courageously (considering what has happened to the likes of Andy Rooney when they dared to suggest that minority factions are sometimes their own worst enemies).

Except for cancer, Mr. Krauthammer writes, AIDS now receives more research money than any other illness in America. AIDS already gets \$1.3 billion. Mr. Krauthammer:

"The AIDS research allocation is not just huge, it is hugely disproportionate. AIDS has killed 83,000 Americans in nine years. *Heart disease kills that many every six weeks*" [emphasis added].

"The suffering caused by AIDS is enormous. Sufferers deserve compassion, and their disease deserves scientific inquiry. But AIDS has got far more. *AIDS has become the most privileged disease in America* [emphasis added]. Why? Mainly because its victims are young, in many cases creative and famous . . . and because one of the two groups that AIDS disproportionately affects (gay men) is highly organized. This combination of conspicuousness and constituency has allowed AIDS activists to get more research funding, more treatment money and lesser drug-testing restrictions than any comparable disease.... In fact, American society is giving overwhelming and indeed disproportionate attention and resources into the fight."

At first the AIDS lobby attempted to convince the nation that no one was safe from AIDS, thus to generate universal fear. That campaign, successful at first, ran aground:

"It wasn't true. AIDS is not everyone's problem. It is extremely difficult to get AIDS. It requires the carrying out of specific and quite intentional acts.

Continued on page 8

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T. Riley Lumpkin, M.D.
President, MASA

Legal Department

As a practicing physician in the State of Alabama or the holder of a state license, one needs to know how the Medical Association of the state functions. We need to know the various divisions, the responsibility and work of each part of the Association. With a better understanding of its anatomy and physiology you as a member can contribute to its effectiveness.

I shall attempt to give you an inside picture of the Association, your Association; explain how you fit into the picture and why the Association needs your input on a regular basis.

The first division to be considered is the *Legal Department* which is headed by Mr. Wendell R. Morgan, our General Counsel. He is a practicing attorney with a Bachelor of Arts (BA) degree from Auburn University in 1965 and his Doctor of Jurisprudence (JD) degree from the University of Alabama in 1969. Mr. Morgan served in the U.S. Army from 1966 through 1968 receiving the Bronze Star for service in Viet Nam.

His private practice started in Montgomery in 1969 and admitted to the Alabama State Bar 1969; to the U.S. District Courts in 1973 and to the U.S. Court of Appeals (11th Circuit) in 1981. Mr. Morgan worked as attorney for the Department of Mental Health from 1976 through 1980 and has been our legal counsel for the Medical Association of the State of Alabama since 1981. He is ably assisted by Sandra Fuqua, his secretarial support.

The duties of our legal counsel are many and include the following for the Association:

- Principal legal advisor to the Board of Censors and Officers of the Association. He meets on a regular basis with the subcommittee on Association Affairs and the Grievance Task Force.
- He counsels and advises the Executive Director, Mr. Lon Conner, and the various department heads of the Medical Association headquarters staff.
- Represents the Board of Censors and Alabama Board of Medical Examiners (ABME) in litigation before state and federal courts and regulatory agencies.
- Supervises and coordinates the activities of outside counsel as requested.
- Advises the Executive Director and Association Officers concerning the interpretation of the Constitution and Bylaws of the Association.
- Prepares proposed amendments to the Constitution and Bylaws.
- Advises the speaker of the House of Delegates and College of Counselors on matters relating to parliamentary procedure during the meeting of the Annual Business Session.
- Assumes responsibility for conduct of a district caucus and the meeting of Reference Committee at Annual Session.
- Provides assistance to the Legislative Department by research and review of legislation and the drafting of proposed legislation.
- Receives, refers and disposes of complaints to the Association involving legal matters.
- Participates in educational programs for physicians



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and physician support personnel and renders advice to physicians on a wide variety of legal questions related to medical practice.

- Contributes timely information to the Association and ABME publications on current legal developments.

Our Legal Counsel also acts as the principal legal advisor to the Chairman of the Board of Medical Examiners, Earl Riley, M.D., the Chairman of the Credentials Committee, Jim West, M.D., or the Executive Director, Senator Larry Dixon, and the Board of Medical Examiners. His counsel relates to the interpretation of state law governing the licensing and disciplining of physicians licensed to practice in Alabama.

His cohort and ABME staff attorney, Patricia "Trish" Shaner, received her BS degree from the University of Alabama in 1972 and MS in 1973 and received her JD after attending Cumberland School of Law, Samford University, 1976-79.

- They provide legal advice to the Executive Director, Senator Larry Dixon, and the investigative staff on conduct of investigations by the BME (Board of Medical Examiners).
- Represents the State Board of Medical Examiners and individual members in state and federal courts and before regulatory agencies.
- Prepares hearing notices, subpoenas and other legal documents related to hearings before the Board of Medical Examiners.
- Presents cases related to controlled substances to the State Board of Medical Examiners.
- Prepares formal complaints and participates as attorney for the Board of Medical Examiners in hearings before the Medical Licensure Commission of Alabama.
- Researches and reviews proposed legislation and drafts legislation sponsored by the Board of Medical Examiners.
- Reviews, prepares and interprets rules and regulations of the Board of Medical Examiners and implements the requirements of the Alabama Administrative Procedure Act for the Board of Medical Examiners.
- Coordinates with the Medical Licensure Commission of Alabama in interpreting the state law and the handling of complaints filed by the Board before the Commission.
- Supervises activities of staff attorney and legal secretary.
- Monitors all bills introduced in Alabama legislature to identify and respond to any bills affecting operations of the Board of Medical Examiners and its employees.

More information will be given in future articles on the publications of the Legal Department. Also, each month will bring more about the different divisions of your Association. Look for the next revealing chapter. □

The Nature Of Things

Continued from page 4

Nine out of ten people with AIDS got it through homosexual sex and/or intravenous drug use.

"The . . . demonstrators, therefore, now appeal less to solidarity than to guilt: every person who dies is more blood on the hands of a society unwilling to give every dollar demanded for a cure.

"But society has blood on its hands every time it refuses to give everything demanded by the cancer lobby, the heart disease lobby, the diabetes lobby. So now a different tack: the claim that the AIDS epidemic is . . . an act of God—and government has not done enough to help its helpless victims.

"In fact, AIDS is far less an act of God than is, say, cancer or diabetes. Apart from a small number of relentlessly exploited Ryan White-like exceptions, the overwhelming majority of sufferers get AIDS through some voluntary act: sex or drug abuse. You don't get AIDS the way you used to get TB, by having someone on the trolley cough in your face. You don't get it the way you get, say, brain cancer, which is through some act of God we don't understand at all.

"AIDS is in the class of diseases whose origins we understand quite well. It is behaviorally induced and behaviorally prevented. In that sense it is in the same moral class with lung cancer, the majority of whose victims get it through voluntary behavior well known to be highly dangerous As a society we do not refuse to either treat or research lung cancer simply because its sufferers brought it on themselves. But we would find it somewhat perverse and distasteful if lung cancer sufferers began demonstrating wildly, blaming society and government for their problems and demanding that they be first in line for a cure.

"Many people contract AIDS before its cause became known, about six years ago. For them it is truly an act of God. For the rest . . . it is an act of man. They, of course, deserve our care and treatment. But it is hard to see from where they derive the claim to be first in line— ahead of those dying of leukemia and breast cancer and stroke—for the resources and compassion of a nation."

If, as gays charge, American society is deeply and irreversibly homophobic, a backlash is predictable. That backlash will follow heightened public awareness that AIDS is preempting entirely too much of the health dollar, arguably sentencing to death thousands of victims of other diseases by the disproportionate diversion of limited resources. □

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Dr. Holwick outside of hospital where she practices as a civilian traumatologist.



Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.;
University of California School of Medicine.

RESIDENCY Harbor General Hospital – UCLA
Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital;
Huntington Memorial Hospital, Pasadena, California;
Traumatologist, Arcadia Methodist Hospital, Arcadia,
California.

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“As a Reserve physician, I’ve had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I’ve grown as a physician and as a person.

“I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I’ve been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I’m serving my country.”

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References

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2. *Br J Clin Pharmacol* 1985;20:710-713
3. *Data on file*, Lilly Research Laboratories
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5. *Am J Gastroenterol* 1989;84:769-774



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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

Axid[®] (nizatidine, Lilly)

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Axid[®] (nizatidine, Lilly)

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L). The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Additional information available to the profession on request.



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Medicare Physicians Reimbursement

Jack Hyman, M.D.

During the last two years it seemed obvious that major changes were going to occur in the way doctors are being reimbursed for the treatment of Medicare patients. I found it very difficult to follow the ongoing events that were mitigating and affecting these changes.

For that reason I began to try to chronicle many of these initiatives in some understandable way for my own edification. Consequently, I have assembled most of these issues into a presentation, some of which I gave to the Alabama Urologic Association last year.

Just a bit of historical data that would introduce the subject. What seems to be the driving force behind this unrelenting push to change our reimbursement? Well, the overriding reason that I can see is that physician services are just costing too much. It doesn't matter that these costs are justified and that we give patients professional skills, concerns and compassion that make the cost a real bargain. The numbers that supposedly support this contention of excessive costs are quoted repeatedly. They are frequently misstated to suit the purpose of the so-called expert who, in most instances, is not one of our acknowledged supporters.

What about the numbers? These are quoted time and time again to support the claims of excessive costs. Let's look at some of them. Here again, numbers can be manipulated to the advantage of the manipulator, but the numbers that hurt us the most are these.

As you will see, much of the data is contradictory, particularly as it relates to expenditures for physician's services which make up the major part of Medicare Part B expenditures. They say that the annual growth rate of expenditures for Medicare Part B services has been in the neighborhood of 13% a year. This, as you can see, if accurate, has indeed exceeded the CPI. During the 1987-88 year, the increase has amounted to 17%. When you compare it to a 12% increase in defense expenditures, it becomes to some, an alarming issue. Of that 17% increase, only 4% was due to an increase in the number of enrollees in the Medicare program.

There was a 50% increase in the total volume of services and a 35% increase in the cost per enrollee. There was a 40% increase in diagnostic tests and procedures. Even Dr. Phillip Lee, Chairman of the Physician Payment Review Commission, had made the statement that the total spending for physicians increased on an average of 15% a year from 1981 to 1986.

Yet in an appearance before Congress this year, he contradicted himself when he said fees had been reduced by over 24% during that interval, adjusted for inflation. During that same time frame, Medicare reduced payments to hospitals by 7% through the use of the prospective payment system. In reality, Medicare reduced payment for specific services to physicians by about 13%. One clear evidence of this is, currently, physicians are allowed about 73% of their historical charge for an office visit. Hospitals have fared no better. Dr. Carroll McCarthy of the American Hospital Association, has pointed out that during the last several years hospitals, as well as doctors, should have been getting consumer price increases in reimbursements, but instead the increases to hospitals from 1984 to 1989 was 14.9% as compared to an actual 28% increase in cost of goods and services.

The Part B expenditures, which lumped together a variety of ancillary medical services as well as diagnostic tests, have increased. But they have been misrepresented to lay groups as being physician fees. These increases have happened in spite of the fact that doctors fees have been frozen by the fee freeze. We have had small increases that have not kept up with the CPI. Fees were further restrained by the Maximum Actual Allowance Charge, or MAAC that limited the charge that nonparticipating physicians could make.

Still, doctors fees got all the blame for Part B increases. It is clear to me that the increases in total expenditures for Part B services can be justifiably explained by the cost of technology, the volume of services to more severely ill patients, and the inflation in medical drugs and supplies used by doctors.

A recent AMA white paper points out the high cost of medical care, including physician payments, are reflections of the American standard of living, the highest and best in the world. We have more autos, television, CAT scanners, lithotriptors, etc. We spend more on sports, amusement and leisure. We feed and protect most of the world. We see no reason to change. Rather, as more people enjoy it, that living standard will become even higher.

All of this notwithstanding, we do things in the country by consensus, and the consensus is that doctors are getting too many of the dollars spent on Medicare. The government, as a payor for these services, has seen fit to address this assessment. Some of the ways the government is doing this is the essence of this presentation.

GOVERNMENT RESPONSE

The first thing the government thought they needed to address was physician fees, so in the 1986 Congress, through the mechanism of the Consolidated Omnibus Reconciliation Act of 1985, Congress provided the funds to award a contract of \$1.5 million to William C. Hsiao and his group at Harvard to use to develop a relative value fee scale that would be the basis of fees to physicians on a more equitable basis. There were other groups in the country that tried to get this contract, including the AMA and the College of Surgeons, but the contract went to the independent group at Harvard with the AMA as a participant in the contract.

The AMA's efforts were to center around being sure that the experience of the practicing physician were included in the study, and furnishing methodological advice. The AMA was also to work with the national specialty societies to secure nominations for physician consultant groups and supply a nationally representative sample of physicians from the AMA physician master file.

The impetus for this change in physician reimbursement to a Resource-Based Relative Value Scale, seemed to come from the American College of Physicians, The American Society of Internal Medicine, and from the American Academy of Family Physicians, all organizations who had complained to Congress and to many others that their cognitive services were inadequately compensated.

This, in addition to the awareness of Congress that the Health Care Financing Administration considered some surgical procedures to be greatly overpriced, all helped to being about a general consensus that a fee schedule for all medical services would be desirable and the essence of the fee schedule ought to be a methodology to make all fees more equitable.

The ACP went so far as to claim that fee reform would create the right enticement for providing optimum care for patients. There is some consolation in that, if you recall, before this time, there was some agi-

tation in the Congress to pay physicians on a DRG basis or to combine hospital and physician payments on a DRG basis and let the two of them decide who gets how much.

PPRC

To further address the problem with excessive cost escalation, Congress created and appointed the Physician Payment Review Commission. This Commission was mandated by Congress in 1986 by the Consolidated Omnibus Reconciliation Act of 1985.

The Commission was charged with the role to act as an independent source of advice to the Congress and the Secretary of Health and Human Services in regard to physician payment changes in Medicare Part B. Congress then expanded the mandate in 1988 (P.L. 100-647) to consider *all* policies that have the potential to moderate the rate of increase in expenditures and utilization of services for patients of all ages.

The Commission had 13 members initially: seven health economists and six physicians. Only three are practicing physicians. Currently only five physicians are present, since one has been replaced. It has expanded its scope to address Medicaid as well as Medicare.

Congress appropriated significant funds to staff the Commission to allow for subcontracting to independent survey organizations, computer programming firms, and other purveyors of expertise that they need. The Commission had made its initial report to Congress earlier last year and the broad recommendations of the PPRC were as follows:

1. It proposes that a Medicare fee schedule be based primarily on resource costs.
2. It would place limits on balance billing to limit the beneficiary's financial liability.
3. It would establish expenditure targets to control the growth of expenditures.
4. It would promote research on the effectiveness of medical services.
5. It will assist in the development of practice guidelines to facilitate physician practice review.

It is certainly the most influential advisory body ever created in health care, as it relates to physician reimbursement.

We might look at these recommendations and see what has happened to them since the initial report.

I am not going to address the elements of the fee schedule per se. The Hsiao group and the PPRC are both still working on it. No one I know of has seen the finished product and yet, some important fee changes are occurring based on it. Uniform coding was a problem that needed to be resolved. Procedure codes appear to be easily adapted to the new fee schedule. However, new codes will need to be developed by the PPRC for evaluation and management services, so-called "visit codes." They will need to reflect the time spent as a

measure of the work done. The PPRC is funding a study being done by Dr. Roy Laskin and conducted by Burch-Davis Associates, an opinion research group out of Princeton.

They will ask some 450 physicians to keep a log of the work done and the time spent in a variety of clinical situations treated in the office. To do this, they will be sent a clipboard and a digital clock so that they can log the time that is spent in taking a history, chart dictation, contact with other providers, clinical contact with house staff and scheduling and obtaining lab work. In this way they would establish uniform coding for specific services so that the physician using the same code could be uniformly and fairly compensated for their time and effort.

What's more, based on a fee schedule we have not seen and that has admittedly not been completed, the PPRC has selected 36 procedures as being overpriced. They represent fees at least 10% over the new resource-based fee. The Budget Reconciliation Act of 1989 uses the present geographic payment localities prevailing payment as representative fees. Payments will be reduced by one-third of the difference between prevailing fees and the new RBRVS fee assigned to these procedures (of course, adjusted geographically for differing practice costs and a 25% area earnings differential). The total reduction, however, was not to exceed 15% at any time in any place.

List of Procedures Affected

Breast Surgery
Hip Procedures
Bunion Correction
Knee Arthroscopic
Procedures
Sinus Procedures
Larynx Procedures
Lung Surgery
Pacemaker Procedures
Replacement of Aortic
Valve
Coronary Artery Bypass
Artery Repair
Rechanneling of Artery
Visualization of
Mediastinum
Intestinal Surgery
Appendectomy
Colonoscopy
Gallbladder Removal
Hernia Repair
Fragmenting of a Kidney
Stone

Prostate Procedures
Dilatation and Curettage
Hysterectomy
Vaginal Hysterectomy
Removal of Spinal
Lamina
Spinal Disc Surgery
Revision of Cranial,
Ulnar, Medium Nerves
Eye Surgery
Lens Procedures
Detached Retina Repair
Treatment of Retinal
Lesion
Eardrum Procedures
ECHO Exam of Abdomen
Ophthalmoscopy
Eye Evaluation
Cardiovascular
Procedures
Heart Catheterization
and Biopsy

Source: Physician Payment Review Commission

RBRVS PHASE-INS

The remainder of the Resource-Based Relative Value Fee Schedule was to be phased in gradually, starting in 1992. Until then all fees were frozen until April of 1990,

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instead of receiving the January MEI update. The reduction of 2.9% by the Gramm-Rudman cuts was reduced to 1.4% for the rest of the fiscal year and through March, 1991. After April 1 of this year, primary care physicians got a 5.3% increase. Everyone else got a 2% increase minus the 1.4% Gramm-Rudman, except for the over-priced procedures where no increase was given. Anesthesia and pathology were handled separately. New physicians were to be compensated at 80% of the prevailing fee and will be brought up to 100% over the ensuing four years.

THE 1989 BUDGET ACT

Based on a formula geared to the Medicare Volume Performance Standards, which we will discuss later, the RBRVS fee schedule will become operational over a five-year period beginning in 1992.

Assuming that in January 1991 there will be an update that would represent the usual MEI percentage increase for the year, then each year following that the prevailing fee schedule will be blended so that in 1993 the blend will be the previous year's fees blended with 25% of the determined RBRVS fee. In 1994 the previous year's blended fee plus 33% of the RBRVS fee will be the new blended fee. In 1995 a 50/50 blend of the previous year and the RBRVS fee will be the prevailing fee. In 1996 the fees will be all adjusted to represent the RBRVS fee.

I stated before the fees generally will be adjusted to geographic practice costs and a 25% area earnings differential, with some compensation for malpractice insurance costs considered separately. Hopefully the separation of malpractice costs will emphasize the magnitude of this factor in addressing total fees. It may spur Congress into doing something about malpractice insurance costs by passing needed national tort legislation.

BALANCE BILLING

Mandatory assignment, as you know, has been fought for many years by the AMA in particular as the one thing that we had remaining that left us our professional fiscal integrity. Yet, in Alabama, it has become a relatively minor issue as far as most physicians generally are concerned. In Alabama over 70% of the doctors voluntarily accept assignment or accept as full payment what Medicare reimburses. In the private sector programs, Blue Cross/Blue Shield's PMD program, which has over 40% of the market in the state, mandates that one accepts their payment without balance billing.

The Medicaid program, which consists of 9.5% of the billings in the state, also limits the rights to balance bill. The PPRC was suggesting on a nationwide basis, that the non-participating doctors be allowed to charge, as a maximum, a small percentage over what the allowable is for Medicare. The significance of this balance billing is apparent nationwide when one considers that in 1987 \$2.5 billion were extra billed on non-assigned claims. It certainly seems like an awfully high number.

Currently, the Maximum Actual Allowable Charge, or MAAC, determines one's individual limits on patients balance billing that the non-participating physician can charge. The new Reconciliation Act of 1989 extends the Maximum Allowable Charge concept into 1991-1992. There will be a new cap, however, of 125% of the allowable payment in 1991, 120% of the allowable Medicare payment in 1992. That is that cap or the individual Maximum Allowable Charge, whichever is lesser.

In 1993 and beyond the maximum allowable will be 115% of the blended Medicare payment as previously determined. It is interesting that the 125% cap which will go into effect next year, in some instances will be less than one's current MAAC, forcing a fee reduction that the law did not mandate. This certainly needs to be addressed and the PPRC is aware of it.

EFFECTIVENESS RESEARCH

The PPRC has recommended to Congress that there needs to be research done on the effectiveness of medical treatment. Much data has been accumulated, with the allegation that much of the testing and considerable amount of treatment is ineffective. The Rand Corporation, a year or so ago, published their review of thousands of coronary bypass procedures in which they said that 50% of them were clearly inappropriate. At the same time, they indicated that carotid surgery was being done on a large percentage of patients that did not fulfill established criteria. This same organization has chosen other surgical procedures, finding that they think they are done many times when they are not needed. It follows that, if procedures are done inappropriately, they should be ineffective. The AMA has contracted with the Rand Corporation to develop more data to assess these findings, to see if some meaningful initiatives can be started on the basis of new data. The Rand Corporation has led the administration to believe that if they would commit \$90 million in effectiveness research they could save \$110 million in 1992. The Congress committed \$53 million for 1990.

RAND CORPORATION STUDY

It is of interest to us to examine the Rand Corporation methodology for studying appropriateness. In each instance there were 1500 procedures that were reviewed using a nine-member multi-specialty panel to develop criteria for that procedure. The panel developed a list of detailed, clear indications derived from a literature search and review. The panel rated the indications on a scale of 1 to 9, grouping them into three categories. Appropriate indications had a median rating of 7 to 9 with the higher ratings being the most appropriate indications. Inappropriate indications had a median rating of 1 to 3 with those lower rating indications being the most inappropriate.

An equivocal rating was one that ranged from 4 to 6 in the list of rating of indications. There was an effort

made to establish whether there was agreement among the rating panel and it was determined that agreement occurred when 7 ratings or seven individual ratings fell under a 3 range. There was disagreement if three were from 1 to 3 or three ratings fell under a range of 7 to 9.

The obvious initial criticism to the Rand methodology is the lack of any effort being made to use physician evaluators in the same discipline as the procedure that was being reviewed. The American Medical Association partnership with the Rand Corporation will utilize specialists in the same discipline in the development of effectiveness or appropriateness criteria.

The HHS has also established a medical treatment effectiveness program. It will study outcomes and methods to improve the effectiveness of medical treatment. It has established the National Center for Health Services Research and Health Care Technology Assessment, which has awarded grants to fund research on effectiveness of treatment of initially, such conditions as prostatic enlargement, myocardial infarction, cataract removal and low back pain.

Assessment teams will be consisting of practicing clinicians and other experts who will examine comparative effects of alternative treatments on patient survival, quality of life and other factors. The methodology to be used was to be developed by the "Institute of Medicine." It was contemplated that it will take five years to complete the study. There has been \$5.9 million appropriated to fund fiscal year 1989 with an

increase to \$52 million carrying over into fiscal year 1990. A total of \$850 million is projected to be spent in the ensuing five years.

A new law just passed by the Congress has supplanted the Center for Health Services Research by a new agency for health care cost, Health Care Policy and Research, as part of the Public Health Service. It will be doing the same thing as the original center for Health Service Research, but it has agency status and can command more funding and ranks higher in the bureaucratic ladder.

PRACTICE GUIDELINES

The Physician Payment Review Commission is calling for the federal government to support development of practice guidelines by funding, coordination and evaluation with the private sector in developing these guidelines. Federal oversight was thought to be needed to focus on the integrity of the process, the quality of the methods used, and the quality and use of the guidelines. The American College of Surgeons and surgical specialty societies indicated a willingness to assist in developing practice guidelines.

We have no problem with guidelines if they are used correctly. The 1989 Budget Reconciliation Act created the new Agency for Health Care Policy and Research within the Public Health Service that we alluded to before. This agency was to spearhead the development of practice guidelines. Its "forum for policy and effectiveness in

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health care" will oversee the development of guidelines for all medical care not just for Medicare patients. Congress has appropriated \$30 million for 1990 for starters, and it now has \$98.8 million to work with.

The AMA and specialty societies are not eligible for funding from this agency, but rather the funding will go to independent research groups like the Rand Corporation and others. It will establish its own panel of providers and consumers to develop guidelines using the methodology developed by the Institute of Medicine.

The AMA House of Delegates directed the AMA to develop two working groups to work on practice parameters (guidelines): The AMA Speciality Society Practice Parameters Committee; which will include large specialty groups; and the "Practice Parameters Forum," which will include all the rest of the specialties and the interested state societies and AMA councils.

The AMA has contracted a partnership with the Rand Corporation and a consortium of academic medical centers to develop practice guidelines. Originally delayed, the project at the present time is just about to get started on four major procedures. Presently the consortium consists of nine university centers selected for special expertise. Eight more centers are to be added, all to be called the Academic Medical Center Consortium. Once the parameters are developed, other groups will evaluate their adequacy and usefulness.

The AMA, in addition to this, published what they considered to be the attributes of quality parameters and a guide to developing new parameters. They also published a list of existing parameters which had been previously developed. The AMA office of General Counsel has just recently published a report of the legal ramifications of parameters. These include the impact on medical malpractice liability, anti-trust and tort liability for medical associations that develop the guidelines, tort liability for third parties and insurers that use them.

I think it is interesting to conjecture how these guidelines are to be used. Robert Brook of the Rand Corporation, in a recent JAMA article, stated that we need to develop a controlled institution capable of developing and maintaining practice guidelines for common diagnoses and procedures. It should test and report, on a periodic cycle, all the guidelines developed and should be outcome based and outcome justified.

He postulated that the physicians of the future might well have a desk top computer with access to guidelines with explicit appropriateness ratings. These might form the basis of discussion with the patient on the use of costly high tech procedures and could let you share with them the responsibility for insuring a high quality of care.

I believe if guidelines would establish acceptable limits of care so that they would protect us from litigation and eliminate the excesses demanded by defensive medicine, they would be worth all the effort and expense.

EXPECTATIONS AND RESULTS

All this increased regulations certainly has a possible byproduct that would be less than desirable. It could do a good deal more harm than good. It could cost a lot more than it saves. This happened previously to the PRSO. As you recall, some years ago 100 million physician hours were spent at a cost of about \$100 million developing so-called guidelines for quality care in almost every conceivable clinical setting. There was little coordination of all the effort that was done and the government abandoned the project when it was found not to be cost-effective.

Dr. Robert Brook tells us that good appropriateness criteria will cost \$150,000 to \$500,000 per condition to develop. He has the data to support that cost estimate. In the private sector the Value Health Computerized Medical Review System was developed using Rand Corporation methodology by one of its former principle investigators. It is being used by the Minnesota Blues for pre-procedure review of appropriateness. It costs the user several hundred thousand dollars a year. It has detected about 6% inappropriate procedures. It creates the dilemma of physicians having to inform and explain to the patients the denials of procedures that the system deems inappropriate. It creates a liability for insurance companies if they fail to inform the patient when the procedures is done anyway and an ineffective outcome results. Payment denials will be the next thing to come along based on these appropriate criteria.

PRACTICE PARAMETERS

The AMA says that practice parameters should be quality assurance instruments, not a means of saving money. The physician variance should be a signal for peer review consideration. Well, it is hard to believe that the government is willing to spend \$850 million to develop effectiveness parameters to educate physicians. What they are looking for is a 6% to 12% reduction of inappropriate treatment or procedures to reduce cost. Dr. Sullivan has already indicated that he feels that 25% of treatment and procedures that are done are medically unnecessary.

Such a statement is not justified when Medicare peer review organizations are finding that only 4% are medically unnecessary after their intensive review. We all know that a treatment decision has always been a patient-physician decision and we admit that at times we need to improve the capacity of physicians to make better decisions based on scientific data, but at the same time we realize that there is more to good treatment than scientific data.

Someone has said there is more interest in avoiding care than paying for it.

EXPENDITURE TARGETS

The PPRC had recommended that expenditure targets be developed and used to curb the growth of expen-

ditures for Medicare services by physicians. These were supposed to be used to determine the annual conversion factor update under the projected fee schedule. Whether the update should be higher or lower than the increase in practice cost would depend on the difference between actual and targeted expenditures. The PPRC recommended the same targets for all physician services, not separate targets for surgery as the American College of Surgeons was asking for.

VOLUME PERFORMANCE STANDARDS

The American Medical Association lobby worked extremely hard to prevent the enactment of expenditure targets. A host of organizations such as the AARP, the Villers Foundations, the National Council of Senior Citizens, AFL-CIO, Catholic Golden Age and Catholic Charities, the American College of Surgeons, and in particular, Congressman Pete Stark of the House Ways and Means Committee, were all staunch supporters of the concept of expenditure targets.

These organizations have been sold the concept that this was a cost control mechanism for Medicare instead of a fee-cutting mechanism for physicians. Certainly the way that some people intended expenditure targets to work, it might well have been a significant cost cutting mechanism by rationing health care.

The issue of expenditure targets was addressed by the Senate Finance Committee under Senators Donald Dursenberger and Jay Rockefeller. They came up with

what they call Medicare Volume Performance Standards, a concept that was much more acceptable to the American Medical Association but still, as Senator Rockefeller has himself conceded, was a way of linking fees to expenditures, but not dollar for dollar.

Medicare Volume Performance Standards have established a growth rate of expenditures annually for physician payments that would be 1/2 or 1% less than if there were no volume standards. This growth rate was thought to be between 9-1/2 and 10%. Actually the Secretary has set a growth rate of 9.1% for fiscal 1991.

The methodology of Medicare Volume Performance Standards would be determined by establishing the actual total expenditures in 1990 as a baseline standard. This along with other factors, such as access to service, the Medical Economic Index, etc., would be the basis for recommending a fee update in 1991. Theoretically, the annual fee update, as in the past, should be the same as the Medical Economic Index. However, Congress, critically, would have the final say on the fee update and with the advice from the PPRC, would determine the Medicare Volume Performance Standards for the ensuing year. Expenditure targets, volume standards — as a well known Alabama politician used to say about the two major political parties, "There is not a dime's worth of difference between them."

DEFAULT STANDARDS AND UPDATES

Fortunately, Congress is the key to all of this. It's

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much better than Congress control this activity than the HCFA of HHS. If Congress fails to enact a fee update or a new volume standard, then the mechanism is in place for a so-called default fee update and default standard to be mandated. The default standard is automatically 1% less than the growth rate that normally would have been anticipated in 1991 – that is, 1% less than 9.1%. If Congress continues to default in setting up these standards, in the following year, 1992, it would be 1-1/2% less than the preceding year. Subsequently, it will be 2% less in the following years.

The fee update would depend on how close the actual spending came to the MVPS. The degree that the update could be used to recoup spending would be limited. In 1992 and 1993 the fee update could be no lower than the Medical Economic Index minus 2%. In 1994 and 1995 the fee update could be no longer than the MEI minus 2-1/2%. In 1996 and thereafter the update could be no lower than the MEI minus 3%.

MODIFICATIONS AND EXCLUSIONS

Separate volume standards are supposed to be established for surgeons. This was mediated by the American College of Surgeons and subsequently, separate standards could be possible for other categories of service. HMO's with Medicare risk contracts would be exempt from the standards and at the pleasure of the Congress, other qualified physician groups, such as medical staffs, might be able to negotiate separate standards with the government, and opted out of the national standard.

The HHS, through the Secretary, has developed a list of services which are to be included in the volume determination for the year. In addition to physician service, they include:

- Physician services
- Services and supplies furnished incident to physician services
- Outpatient physical, speech and occupational therapy
- Antigens prepared by or under the supervision of a physician
- Services of physician assistants, nurse anesthetists, nurse midwives, psychologists and social workers
- Diagnostic x-rays, lab tests, and other diagnostic tests
- X-ray, radium and radioactive isotope therapy
- Surgical dressing, splints, casts, and other devices for reducing fractures and dislocations
- Others will be added as needed.

This list became law after being published in *The Federal Register* and they were unchallenged after 90 days. It would seem grossly unfair to have an update in physician fees be dependent on services not directly attributable to physicians. Fairness to doctors is no longer a consideration by the government.

SOME ABSURD EXPECTATIONS

Senator Rockefeller: "This is the vehicle we hope will begin to change not just the behavior of medicine, but all

of us who are demanding medical care as well." Dr. Lewis Sullivan, Secretary of HHS: "The real advantage to setting a performance standards rate of increase is that for the first time practicing physicians will be involved in the effort to bring acceptable rates of growth under control. The new law will slow the rise in fees doctors charge and slow the growth in volume of services."

I ask you, how can we do these things without rationing care and certainly getting paid less for what we do?

WHAT CAN WE DO?

We must recognize that the whole process of Medicare reimbursements for Part B is controlled by the politicians, the House Ways and Means, Energy and Commerce Committees and the Senate Finance Committee. For us to be a party to the negotiations in Congress we must have access to our congressional representatives to discuss these issues with them. This takes more than a casual acquaintance. To establish a relationship requires your support at election time, support of money and time. You cannot buy influence, but you can get access and interest to your problem and point of view.

It is extremely important that we support the lobbying and election efforts of our national organizations. They speak for us before the committees and Congress. All this takes money. The little it will cost us to support the efforts will hardly be missed. So contribute! That's what it takes – contribute.

TOMORROW AND BEYOND

The administration's 1991 budget is more of the same. It looks for saving \$5 billion more from Medicare, over one billion at the expense of doctors. One billion directly at the expense of doctors' fees. The Gramm-Rudman cut of 1.4% will be continued through April of 1991. There will be an additional cut made in the 36 overpriced procedures with the addition of other procedures that they have estimated to be overpriced as compared to the RSVS fee schedule.

These cuts could be as much as 25% or more of the differential. Payments will be delayed to providers from the usual 14, to 16 days. There is a serious consideration of lumping hospital, physicians, and other providers into a single payment for care of specific disease entities. This is called unit pricing for a standard procedure or illness. In addition, there will be no MEI increase except for primary care physicians in rural areas. It is recommended that all surgical fees be reduced by 2%. They will eliminate assistant fees for most procedures.

SOME PERSONAL OBSERVATIONS

I think the outlook for the private practicing physician is dismal, if we continue as we are. He has no constituency of voters, so politicians have nothing to fear from doctors. We are letting ourselves be fragmented in

our dealings with Congress and the federal government.

We are succumbing to fragmentation in our own communities and losing the effectiveness that we would have in dealing with various provider groups. This has to change. We must insist that the leadership of our organization move rapidly to unite us all, so that we can speak with one voice with some authority and effectiveness. Witness what the state association is being able to accomplish for us in dealing with third parties through the Task Force – something that we could never do on our own.

Somehow the egos of the leadership of our major medical organizations have motivated separate initiatives that many times are conflicting rather than supportive of our own common good. We must get the AMA, the AC of S, the American Academy of Pediatrics, American Society of Internal Medicine and others together, to work for our mutual benefit.

Finally, a good friend of the private practice of medicine, Dr. Harry Schwartz, who many of you may know, writes regularly for the *Wall Street Journal* and *American Medical News*, forecasts that by the year 2000 80% of American physicians will be employed and their average income will be at least 20% less than what it is now.

He urges us to unite to deal effectively with the government and those other payers who would eventually employ us. He has even suggested that we unionize, form a national union. For this to happen we would

have to change the laws under which the FTC operates. The FTC finds that it is perfectly permissible for insurance companies and others to set our fees and regulate our practices, but it is antitrust to collectively oppose their tactics and bargain in our own behalf. The day is fast arriving that we need to do something about this.

I know this account of the sad state of affairs we find ourselves in leaves you with little to pin your hopes on for the future. In spite of it all, I still believe we hold our destiny in our own hands and in the hands of those patients out there we serve so well. Some years ago, I wrote a little essay for *Alabama Medicine* entitled, "Our Rendezvous with Destiny." The thesis was that our destiny, meaning the practice of medicine, was not a matter of chance but a matter of choice. It doesn't just happen. It's a thing to be achieved.

These words are not original with me. They were said by William Jennings Bryant in a speech in Washington almost 100 years ago. I ended the piece by saying:

"If the practice of medicine should, God forbid, ever become simply another profit-making business instead of a sacred covenant between physician and patient, we will have forfeited our claim to the transcendent position the profession of medicine has always occupied. If we keep our professionalism, we will keep the trust and confidence of the public. And that is what we should treasure the very most of all. Our very destiny will depend on it." □

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Malignant Melanoma Of The Anus

*Richard S. Gist, M.D.**

John O. Waits, M.D.†

INTRODUCTION

Malignant melanoma of the anorectum is fortunately a rare occurrence. Occasionally, malignant melanoma presents as an incidental finding in a resected specimen. We present a case who presented with thrombosed gangrenous internal and external hemorrhoids and was found to have malignant melanoma of the anus on pathological examination.

CASE REPORT

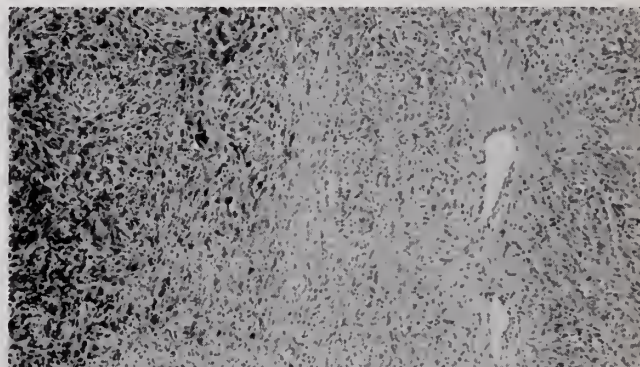
The patient was a 47 year old white male who presented with a six month history of hemorrhoids. He was essentially asymptomatic except for occasional

pain which he described as feeling "scalded on my backside." There was no history of bleeding or irreducible prolapsed hemorrhoids. He was evaluated and found to have third degree thrombosed external and internal hemorrhoids and was advised to have an elective hemorrhoidectomy but initially refused.

Approximately two months later, the patient finally agreed to elective hemorrhoidectomy after his hemorrhoids had progressed to a fourth degree gangrenous state. A five column hemorrhoidectomy was done under spinal anesthesia and gross inspection of the resected specimen intraoperatively showed gangrenous hemorrhoids with the most discolored and gangrenous appearing in the right anterior/midline column specimen. Routine pathological examination of the resected



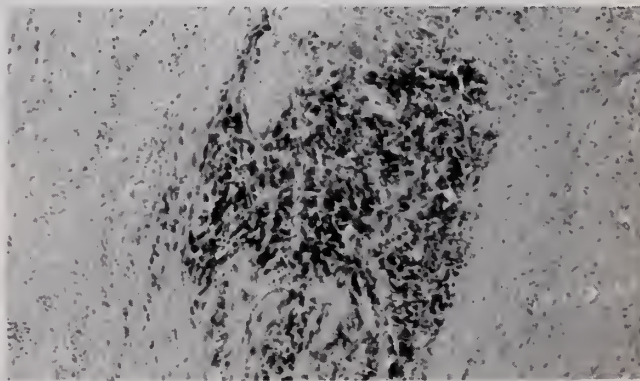
#1-Photomicrograph of the original resected specimen demonstrating the original squamous epithelium with abundant melanocytes and melanin pigment in the dermis.



#2-Magnified view of Figure 1 demonstrating several nests of melanocytes within the dermis.



#3-Photograph of specimen taken at local excision to obtain clear margins.



#4-Magnified view of Figure 2 demonstrating densely packed nest of melanocytes deep within the dermis.

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specimen showed a malignant melanoma invading the submucosa to a thickness of 6mm (Clark's Level V). Abundant melanin pigment was present within the melanocytes and an immunoperoxidase staining procedure was positive and its pattern most consistent with a malignant melanoma.

Treatment options that were discussed with the patient included an abdominoperineal resection with lymph node dissection. The patient adamantly refused all treatment options including chemotherapy but later was amenable to a local resection of the anal tissue to obtain clear tissue margins. Approximately six weeks postoperatively, the patient underwent a local excision of the previous hemorrhoidectomy site under spinal anesthesia. Pathological examination of the resected tissue showed residual melanoma insitu with a focus of deeply packed cells within the dermis but with essential clear tissue margins. Computed tomography scans of the head, chest, and abdomen were obtained preoperatively prior to the second surgery and all scans were negative for any distant visceral metastasis or lymphadenopathy. The patient subsequently refused any further treatment and has been lost to followup for approximately one year.

DISCUSSION

Anorectal melanoma is a very uncommon neoplasm with only approximately 250 reported cases in the literature. The neoplasm was first described by Moore in 1857.¹ The incidence of anorectal melanoma is approximately 0.4 - 1.6% of all melanomas.² This lesion most often occurs at the dentate line/transitional zone but has been reported less frequently in the anal canal proper and occasionally the ischiorectal fossa.³

Prominent presenting symptoms of anorectal melanoma are usually those consistent with most anorectal complaints. In a series of 65 patients,³ the most common presenting complaint was localized bleeding (75%) and the least common was a presenting complaint of "hemorrhoids". Complaints of pain were present only in approximately 35%.³ Weight loss was present only in 22% of patients, presumably due to disseminated disease.³ Mean age of this series of patients was approximately 57 years.

Various treatment modalities have been suggested

for melanoma of the anorectum. The most frequent approach that is advocated is abdominoperineal resection with pelvic and superficial groin lymph node dissection, although comparisons have been made with this modality and local excision with lymph node dissection. These comparisons have shown that both are about equally efficacious.^{2,3} A small series reported by Baskies et al at the National Cancer Institute advocated the use of posterior pelvic exenteration with en bloc node dissection but survival was not improved by this technique.⁴ Radiation, chemotherapy, and BCG

immunotherapy have been unsuccessful as adjuncts to the treatment of anorectal melanoma.^{2,3}

Survival of anorectal melanoma is unfortunately uniformly poor with five year survival rates approximately 5%.² The survival rate appears to depend (as with most melanomas) upon the tumor thickness with the most dismal rates being with those tumors 2.0mm in thickness. The longest survival noted in the literature is that of an elderly lady who had mesenteric node involvement and was alive 10 years postoperatively.⁵ Mean survival time for lesions 2.0mm thick is approximately 24 months.²

In summary, we present the case of an individual

whose lesion was found as an incidental finding. The keys to treatment (and ultimately survival) lie in early detection and treatment of this lesion. Because this lesion is so rare, a high clinical index of suspicion is necessary for early diagnosis of this lesion especially when treating patients for chronic anorectal complaints. □

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Donald S. Tysinger, M.D.*

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(3) He had a stiff index finger on his left hand which made it impossible for him to hold a firm enough grip on the steering wheel to control the truck, and while shifting gears he had lost control.

(4) He had recently had a heart attack, still in the recovery period. He has had ventricular fibrillation occur while he was driving.

(5) etc.

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The physician is the key to assurance of the health and the physical ability of the driver of a commercial vehicle. The State Department of Public Safety is responsible for the person's ability to handle the vehicle being driven. The driver is responsible for the mechanical highway fitness of the vehicle he or she is driving.

There *must* be no compromise from either party. If the vehicle is not fit (highway safe) it should not be driven; this is the driver's responsibility; he is breaking the law and is liable.

If the driver does not have the skilled training to drive the vehicle, and has not passed the written and the thirty-three mile driver's road test, it is the Department of Public Safety's responsibility. If the driver does not meet the physical requirements to operate a commercial vehicle, it is the doctor's responsibility, and the doctor is liable. As physicians we must understand and meticulously evaluate every applicant for a commercial driver's license.

Driving is a privilege, not a right. The driver of a motor vehicle must be mentally and physically qualified to handle any and all emergencies that may arise while driving. These emergencies vary from judging when to pull out into traffic, to a child running out from behind a blind obstruction, to skids, slides, leaving the roadway, to one to four tire blowouts, etc. The driver must be able to handle every conceivable emergency. As a result of poor judgment and an inability to handle emergencies, we have traffic accidents. Drivers have accidents, cars do not.

As a result, for the fiscal year of 1988 (the latest Alabama accident summary), there were 32,741 accidents: 565 were fatal with 634 persons killed, and 16,190 injured.

Of the injured, 10,650 were incapacitating injuries. In addition, there were 3,225 who had evidence of injury, and another 2,315 possible injuries. This is the reason that the Alabama Department of Public Safety must judiciously consider each person applying for a driver's license. The risk, for licensing commercial drivers is much greater, and you, the doctor, are the major public protector. Remember, the life you save on the roads of Alabama may be your own.

The commercial driver must have on his person when driving a commercial vehicle: (1) The original, or a photographic copy of a medical examiner's certificate. The medical examiner's signature certifies that the

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driver meets, without exception, the physical requirements; (2) A valid commercial driver's license for the vehicle and the type of cargo being handled.

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II – Diabetes requiring insulin for control.

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IV – A history or clinical evidence of any respiratory dysfunction that could interfere with the handling of a motor vehicle normally or in acute situations.

V – A history or clinical evidence of high blood pressure, not controllable by diet and/or non-syncopal producing medication.

VI – An established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which would compromise his/her ability to fully control a motor vehicle in any and every conceivable emergency.

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VIII – A mental, nervous, organic, or functional disease or psychiatric disorder that could in any way interfere with his/her ability to exercise sound judgment in operating a motor vehicle safely.

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Impact of Family Physicians' Cessation Of Obstetric Care

*William J. Crump, M.D.**

Claire Marquiss, B.S.†

Peggy Pierce, B.A.†

INTRODUCTION

Family physicians are leaving the practice of obstetrics in large numbers, leading to what some fear may be an "extreme patient care crisis".¹ Increasing liability risk and high premium costs are among the reasons cited by physicians who chose to give up obstetrics. National surveys of family physicians have found that less than 50% of family physicians continue to deliver babies^{2,3} and reports from individual states describe many counties that are without obstetric care.^{4,5,6} In Alabama the number of physicians providing obstetric care dropped from 212 to only 70 in a five year period,⁷ and current estimates are that fewer than 30 family physicians continue to deliver babies.⁶

While this situation presents problems for many women of childbearing age, the effects are magnified among rural women and the poor. Rural patients frequently have to drive long distances to reach physicians whose patient load may be excessively high already.^{4,5} Many physicians prefer not to care for the medically indigent, as those with lower socioeconomic status have a higher risk of complications. In addition, Medicaid reimbursement for those patients who have this coverage has been typically very low.⁴ These access problems may lead to significant increases in maternal and neonatal morbidity and mortality.² We sought to describe the effect on the process and outcome of subsequent pregnancies among women whose family physician ceased delivering babies, as well as the patients' perceived differences between the two pregnancies.

METHODS

The Alabama Perinatal Outcome Project (APOP) was established in 1983 to document maternal and infant outcome in pregnancies managed by family physicians in small community hospitals in Alabama. The APOP is a practice network of family physicians throughout the state which provides an unselected, primary care patient population for study. Research methods, definitions, sample bias and reliability issues for the APOP have been described previously.⁸ Nine APOP physicians at four sites who had recently stopped doing obstetrics agreed to participate in this project.

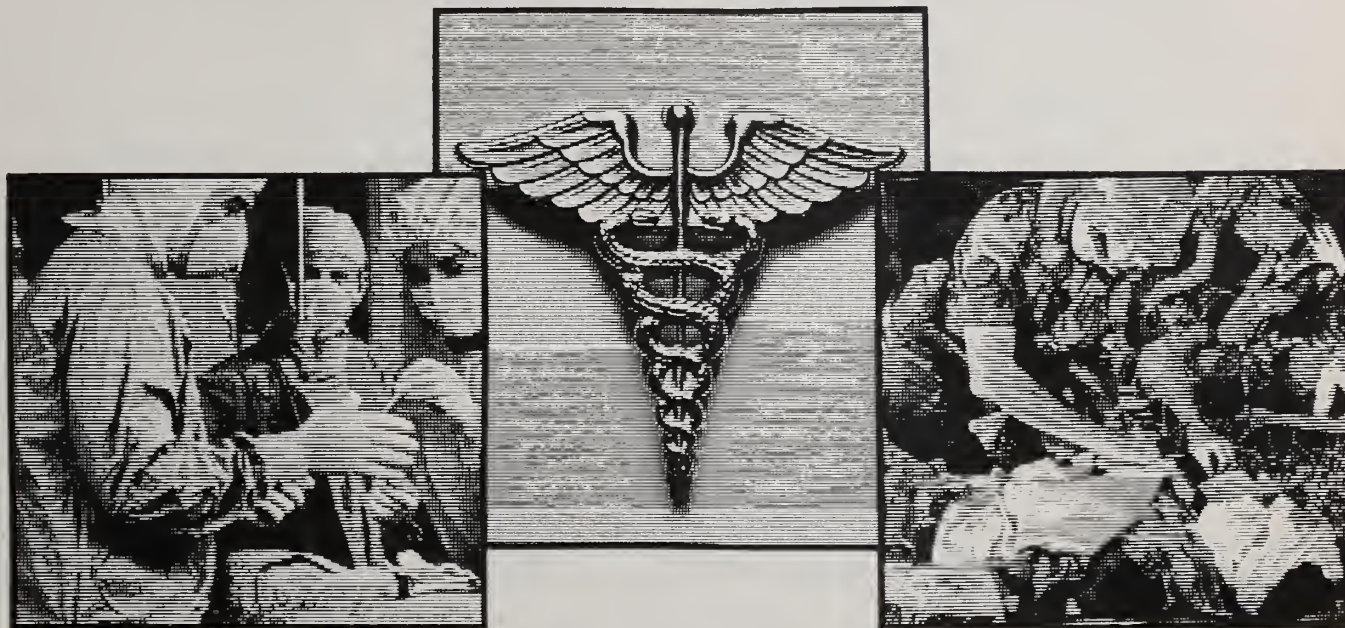
One hundred thirty-four patients were eligible for inclusion in the study as they had not had a tubal ligation after their last delivery. These patients were contacted to determine if they had experienced a subsequent delivery and if they would participate in the study. Thirty-six had not had a subsequent pregnancy. No response was received from 57 women even after several attempts were made to contact them, and 10 could not be located.

The subjects were sent a consent form which explained the purpose of the study and gave permission to obtain a copy of their hospital medical records for their last delivery. These records were used to complete a perinatal outcome form. The perinatal outcome data allows comparisons of pregnancy, labor and delivery variables. The data set used included only those subjects with previous perinatal outcome data in the APOP database. With this information, the two deliveries could be compared.

A questionnaire was also completed by each participating subject. The questionnaire compared the subjects' pregnancy and delivery experience while still under the care of her regular family physician

*Associate Professor, Family Medicine
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to the experience she had after her family physician stopped doing obstetrics. Subjects were asked specifically how far it was from their home to the hospital where they delivered for both their previous and most recent pregnancies, the distance from their home to see a doctor for prenatal visits for both pregnancies, and whether these distances caused them any difficulties. They were also asked about the size of their support network for both pregnancies. Finally, there were two open-ended questions which asked participants to describe the differences between their most recent delivery and the previous delivery, and to describe how the medical care might have been better for the last delivery.

This report will compare the process and outcome of the two pregnancies, in addition to examining the questionnaire data from survey participants which describes the differences they perceived between the two pregnancies.

RESULTS

After three mailings, consent forms and questionnaires were obtained from 31 subjects. Five of these subjects had their first delivery after their regular family physician had stopped doing obstetrics. Data from these five subjects is not included in comparisons of perinatal outcome data, but is included in some of the questionnaire results, where appropriate. Tables 1 and 2 summarize comparisons of deliveries and include only those with subsequent deliveries (N=26). Table 1 shows that the subjects had to drive farther to the hospital where they delivered and farther to see their physician for their second delivery than they did for their first. Subjects reported having fewer friends and relatives that they could count on for assistance within 10 miles of the hospital. Nine (35%) of the women reported that the distance to the hospital caused them problems and half reported that the distance to see their physician was a problem. The differences noted by participants between their latest delivery and the previous delivery are shown in Table 2. Participant comments about the problems caused by distance are categorized by type of prob-

lem in Table 3. Nearly half⁴ of the respondents reported that their medical care for the last pregnancy was adequate. The comments of the other respondents are shown in Table 4.

Complete perinatal outcome data was available for only 19 deliveries. The labor variables shown in Table 5 for the two pregnancies were similar except that the mean Bishop score was higher for the previous pregnancies. Table 6 shows that significantly more women received Meperidine for their previous delivery, while more women received an epidural during their subsequent delivery. As seen in Tables 7 and 8 there were no differences in delivery or puerperium variables, nor were there differences in infant outcome variables.

Finally, a comparison was made between the size of the delivery hospitals and the towns where the deliveries occurred. The subjects' latter deliveries occurred in larger hospitals in larger towns than when their family physician cared for them. There was also a significant reduction in the number of subjects delivered by family physicians. These data are shown in Table 9.

DISCUSSION

With only 31 usable questionnaires, the response rate for the study was disappointing. Locating the eligible subjects and determining which subjects had subsequent deliveries was labor intensive. Even with repeated mailings, the rate of return for the question-

naires was very low.

Overall, it is troubling that so many women responded that the increased distance they had to travel for obstetric care caused them difficulties, particularly where the doctor-patient relationship was affected. Time lost from work and increased travel expenses may add substantially to the cost of having a baby. While no neonatal mortality or morbidity was described by respondents, one woman reported that she nearly delivered in the car on the way to the hospital and another had to be transported by ambulance. Only one woman reported cutting back on prenatal visits but the increased traveling distance for prenatal care may be more of a problem

In Alabama the number of physicians providing obstetric care dropped from 212 to only 70 in a five year period, and current estimates are that fewer than 30 family physicians continue to deliver babies.



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Program Formats – The program will be structured from the papers submitted by Alabama physicians. Time will be scheduled for questions. Registrants and participants will receive advance copy of all papers.

Paper Selection – Papers will be selected using the following criteria and procedures.

1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written materials to be used with the presentation for the study and use of the attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interest to offer a balanced program of general interest.

Symposium Timetable: August 15 to October 15, 1990 – Call for abstracts. October 15, 1990 – Final date for abstracts to be received. Late October, 1990 – Review of abstracts by the Council on Medical Education and final selection of papers. November-January 1991 – Announcements of selections; publicity and promotion of Symposium, printing of abstracts and handouts. January 20, 1991 – Program in Birmingham.

Symposium Topics – To acquaint potential presentors with the kinds of subjects that might be suitable, the speaker and topics at the 1990 Symposium are listed below.

Ruby F. Meredith, M.D. et al – **The Expanding Role of Monoclonal Antibodies in Oncology**; Carl J. Sanfelippo, M.D. – **Prostate Cancer Screening**; P. Douglas Bunting, M.D. – **Subcutaneous Mastectomy & Reconstruction - A Critical Appraisal**; Richard W. Waguespack, M.D. – **The Voice Laboratory: Advanced Diagnosis of the Disordered Voice**; Gary Turner, M.D., et al – **The Uvulopalatopharyngoplasty - to correct obstructive sleep apnea**; Aubrey T. Baugh, Jr., M.D. – **Some Noses I Have Noticed**; Pete Cox, M.D. – **Reflections on Physician Impairment - A Personal Story**; Ronald G. Albright, Jr., M.D. – **Computer-Assisted Medical Information Management**; Robert Y. Kim, M.D. – **Extra Dural Spinal Cord Compression from Metastatic Tumor - Prospective Study**; Andrew E. Lorincz, M.D. – **Flourescence Microscopy for Detection of Superficial Mycoses**; David W. Hodo, M.D. – **Treatment of Elderly Patients With Symptoms of Acute Mania**; Peggy L. Byck, M.D., et al – **Acute Congestive Heart Failure in a 55 year old male**; Rodney Snead, M.D. – **The Alabama Automated Defibrillation Pilot Program**.

Abstracts – Abstracts of the proposed paper (200-300 words, double spaced) should be sent to the Council on Medical Education.

ABSTRACT

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than was reported by this small sample.

Because the most motivated women would be most likely to complete and return the questionnaire, these data are likely to exaggerate the actual differences between the two deliveries. Nonetheless, a clear pattern emerges. When their local family physician was delivering, the drive for prenatal care and delivery was 15-30 minutes, and the women had 2-4 people to help them with care of other children and other practical needs.

After their family physician stopped obstetrics, they had to drive 30-60 minutes, and only had 1-2 people nearby to call on for help. Considering the demands of time and energy of young parents, this could have been a minor inconvenience or a significant crisis.

In their subsequent delivery, these women traveled to cities ten times larger, delivered in hospitals with four times more beds, and were largely cared for by obstetricians. While most tolerated these changes quite well, 42% made negative comments about the subsequent delivery, and none preferred this situation. In addition to transportation and expense issues, 23% cited some alteration in the relationship with their medical caregivers. These women suggested that the increased distance resulted in fewer doctor visits and therefore less opportunity to develop a comfortable relationship with the physician. They were also anxious about the distance to be traveled in labor, and some were uncomfortable in the larger hospitals.

Previous studies have shown a correlation between maternal anxiety and poor perinatal outcome.^{9,13} Although this sample size was too small to detect small effects, the matched design adds considerable statistical power.¹⁴ These patients presented in labor with lower Bishop scores in the subsequent pregnancy. This is the reverse of the usual pattern, suggesting that these women came to the hospital earlier in the labor process because of the distance involved, or their physicians admitted them earlier, or both. This longer in-hospital time could increase maternal anxiety or potentially allow iatrogenic complications.

The management of labor showed some definite differences. There was a shift away from Meperidine analgesia and Pudendal anesthesia towards epidural use. While the numbers are too small in this study to determine any effects of this change, previous studies have shown correlations between epidural use and longer labors, malrotation, and assisted deliveries.¹⁵ There was a trend in infant outcome towards more FHR abnormality and low one minute APGARs in these subsequent deliveries, but all of the important events were too infrequent for reliable detection in this sample size.

The intent of this study was to describe the differences in process and outcome of pregnancy care in women from rural areas when their local family

physician stopped delivering babies. While the response rate was disappointing, the data show some clear differences and suggest others. Larger studies are needed to answer the pressing, critical question: "Just how important is it to maintain obstetrical care by rural family physicians?" □

Larger studies are needed to answer the pressing, critical question: "Just how important is it to maintain obstetrical care by rural family physicians?"

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*Mrs. Charles Patterson
A-MASA, President*

Physicians, Help Yourselves!

I have yet to meet an Alabama physician or his/her spouse who is not unhappy with the relationship between Alabama state laws and the medical profession. Alabama physicians and their spouses are united in the belief that they have a unique insight into the best relationship between laws and medicine. This belief is founded on unselfish dedication, training, and experience caring for patients. However, this belief is probably not understood and therefore not appreciated by the majority of Alabamians. It is also a belief that is actively opposed by some special interest groups of which we are all painfully aware. These political forces are dedicated to further changes in our laws that are in opposition to our beliefs.

If we are to influence the laws of Alabama governing the practice of medicine and their relationship to the people of this state we can and must do three things in the next five months of this election year.

First, every eligible voting member of our families must register and vote for the candidates who

are sympathetic to our beliefs. Voting is the easiest act in politics and one of the best ways to make a difference in the future course of health care policy-making in our state. Since there are approximately seven thousand physicians in the state, this act alone will not always be enough.

Second we must encourage those people we know personally who share our beliefs to take the time to go to the polls and vote. Four telephone calls alone the night before or on election day by each physician's family could have decided the outcome of numerous elections in the state in the last-ten years.

Third, we must finance the candidates who are sympathetic to our beliefs. The impact of this element of our political system cannot be ignored.

We have all heard the phrase "The Lord helps those who help themselves." It can be said that our political system helps those who help themselves and hurts those who ignore. Physicians, you have been hurt long enough – help yourselves! □

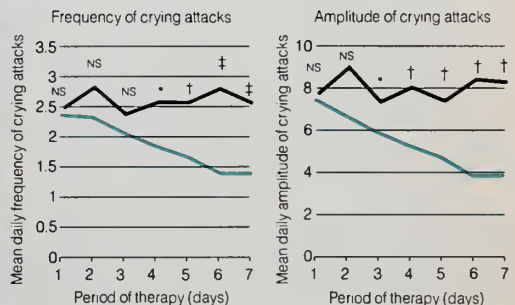
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¹ Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner* 1988;232:508

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VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: Angioedema. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed. Caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hypotension, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure) reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: General Impaired Renal Function. As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure. Patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Hypotension: Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release. The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nifedipine, calcium-channel blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters. There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypotension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use. Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, alaxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Skin: Exfoliative dermatitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, linnulus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: Hypertension. In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered if blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia. In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine > 1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d. or 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19380.

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A white sailboat with a black hull and a black stripe along the gunwale. The name 'ROSE' is written in black on the white hull. A person wearing a bright yellow jacket is standing on the deck. The boat has a tall mast with multiple cross-arms and rigging. The background is a clear blue sky. The boat is reflected in the water below.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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